PREPAREDNESS AND RESPONSE PLAN

ANNEX J

PANDEMIC INFLUENZA

Panhandle Health District
8500 N. Atlas Road
Hayden, Idaho 83835

Panhandle Health District

Annex J: Pandemic Influenza

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Executive Summary

The general public is familiar with epidemics of influenza occurring annually resulting in an estimated 36,000 deaths in the United States primarily in elderly and compromised individuals. These epidemics occur because of frequent minor changes in the influenza virus such that people only have partial immunity from year to year. This means that while people may become ill, the illness is generally relatively mild and of short duration in most who are otherwise healthy.

Periodically, major changes occur in the virus. This "genetic shift" results in a "novel" virus that the world's population has never experienced before and for which there is no degree of immunity. These result in worldwide epidemics, known as "pandemics" which have occurred about three times a century. Pandemics that occurred in 1957-58 and 1968-69 caused relatively small increases in fatalities in the United States beyond that seen on an annual basis with 70,000 and 34,000 excess deaths respectively in these two pandemics. The influenza pandemic of 1918 was especially virulent causing more than 500,000 deaths in the United States and over 40 million deaths worldwide. Especially significant was the number of deaths among young, otherwise healthy adults, a group that normally has very low mortality associated with influenza.

Several characteristics of an influenza pandemic differentiate it from other public health emergencies. By its very nature, it has the potential to cause illness in a very large number of people, overwhelming the health care system across the nation. A pandemic outbreak has the strong potential to jeopardize essential community services by causing high levels of absenteeism in critical positions. Basic services, such as health care, law enforcement, fire and emergency response, communications, transportation, and utilities could be disrupted. Finally, the pandemic, unlike many other emergency events, will last for months rather than days or weeks. It may also occur in repetitive waves. Supply chains for essential items such as food, water, fuel and other emergency provisions may be severely compromised leading to shortages across the region. This could have significant societal consequences causing people to do whatever is necessary to survive and provide for their needs.

Depending upon the characteristics of the new influenza virus, the pandemic can have a range of severity from being relatively mild to being catastrophic. As noted above, there has historically been wide variation in the mortality rates associated with pandemic events. The Centers for Disease Control and Prevention (CDC) have developed a Pandemic Severity Index based upon existing experience and most likely case projections. This index has been used to project potential numbers of ill and deceased in the United States based upon current population figures and is illustrated below.

Centers for Disease Control Pandemic Severity Index by Selected Epidemiologic Characteristics

Characteristics	Pandemic Severity Index (PSI)				
	Category 1	Category 2	Category 3	Category 4	Category 5
Case Fatality Ratio (percentage)	<0.1	0.1 - <0.50	0.5 - <1.0	1.0 - <2.0	? 2.0
Excess Death Rate (per 100,000)	<30	30 - <150	150 - <300	300 - <600	≥600
Illness Rate (percentage of the population)	20-40	20-40	20-40	20-40	20-40
Potential Number of Deaths (based on 2006 U.S. population)	<90,000	90,000-<450,000	450,000-<900,000	900,000-<1.8 million	?1.8 million
20th Century U.S. Experience	Seasonal Influenza (Illness rate 5%-20%)	1957, 1968 Pandemic	None	None	1918 Pandemic

For northern Idaho these CDC estimates translate to the figures below. The number of persons ill with seasonal influenza annually in northern Idaho is between 10,000 and 40,000.

Characteristic	Category 1	Category 2	Category 3	Category 4	Category 5
Number With Illness	40,300 - 80,600				
Potential Deaths	<200	200-1000	1000-2000	2000-4000	>4000

Concern is strong now for a severe pandemic, because over recent years a new virus, the H5N1 or Avian Flu Virus, has emerged and has, as of February 2007, infected a known 272 people worldwide with 166 deaths. This is a relatively small number, but thus far it has only spread from birds to humans or in very rare cases of close contact from person to person. Its mortality rate has been 60 percent, far greater than the 30 percent associated with Smallpox and comparable to the mortality rate of Ebola. If this mortality rate were to be sustained in a virus that was easily transmissible from human to human, rather than the roughly 2 percent associated with the 1918 Pandemic and the CDC estimates above, the mortality figure for northern Idaho would rise to 120,000. Currently the H5N1, Avian Flu Virus, lacks only the ability for sustained person-to-person transmission before it or a virus like it can become the source of the next pandemic.

While the virus might not retain this high mortality rate after developing ability to transmit from person to person, even a fraction of this mortality could be devastating.

The purpose of this plan is to enable the northern Idaho community to minimize, to the greatest extent possible, the impact of such a pandemic. It recognizes that in a pandemic, unlike a sudden and finite disaster, the disaster itself is an ongoing event generating new "casualties" daily and thus provides a different set of challenges from those addressed by many disaster planning efforts.

Overarching goals are ultimately to:

- Limit the number of illnesses and deaths
- Preserve continuity of essential governmental functions
- Preserve social order and function
- Limit economic losses

As a result this plan, in concert with other existing Panhandle Health District plans, provides a framework for:

- Coordination of regional efforts toward mitigating and responding to pandemic influenza
- Identification and methods to limit the spread of disease
- Communication efforts to both prepare the community for a possible pandemic and to provide information if and when a pandemic occurs
- A three-pronged approach for effective utilization of existing healthcare facilities, alternative care centers and home care
- Addressing immunization and medication use if they are available
- Considering the needs of special populations
- Preparation for psychological support for workers and the public
- Support of mass fatality operations

This plan is designed to be a living document, modified as exercises reveal weaknesses. As noted, it is a framework and cannot consider all possibilities, but it sets a course for the planning process.

"No battle plan survives contact with the enemy"
Helmuth von Moltke

"In preparing for battle I have always found that plans are useless, but planning is indispensable."
Dwight D. Eisenhower

The Northern Idaho News of Sandpoint (north-central Idaho), declared that there was no cause for alarm over the flu, but then noted that, as a precautionary measure, schools would be closed indefinitely, and churches, picture shows and all public gatherings of every kind would be prohibited. The newspaper also issued a warning to parents to keep their children away from the railway depots as a precaution against infection.

Opening remarks about the 1918 influenza
pandemic prepared for delivery
at the Idaho State Summit by the
Honorable Mike Leavitt
Secretary of Health and Human Services
March 27, 2006

I. INTRODUCTION

A. Background

Approximately 36,000 excess deaths occur in the United States annually as a result of influenza with most of these occurring in the very young, elderly or immunocompromised individuals. This occurs despite the availability each year of a vaccine designed to prevent or decrease the severity of illness in those who contract the disease.

An influenza pandemic would likely occur in a population with little to no immunity, initially lacking a functional preventive vaccine and in the face of limited antiviral availability. Given this situation, we could hope for a mild pandemic, but there are reasons to be concerned that a more severe contagion is a significant possibility.

The world experienced three influenza pandemics during the 20th Century. The "Asian flu" of 1957-58 and the "Hong Kong flu" of 1968-69 were relatively mild events in the United States. The "Spanish flu" of 1918-19 was strikingly different. As we look ahead, there is historical guidance that assists us in understanding the potential concerns of the next pandemic.

The 1957-58 and 1968-69 pandemics were similar in that they appeared to have been caused by viruses containing genes from a human influenza virus and an avian influenza virus. While the resulting viruses were novel viruses new to the human population and thus resulting in a pandemic, the inclusion of human virus genes may have both moderated their effect and made them not totally unfamiliar to the human immune system. Alternatively, the 1918-19 influenza appears to have had a direct avian origin making it totally foreign to human experience. History has shown that completely novel diseases introduced into a population have devastating effects, while over time the virulence is lessened in a population that has had time to adapt to the presence of the agent.

The current concern associated with the H5N1virus is that like the 1918 virus, it is an avian virus that has shown the ability to directly cause disease in humans. At this time, unlike the 1918 virus, it has not developed the ability for easy communicability from person to person. Should this occur, there is a potential for a 1918-type event. There is no certainty that this will occur, but the H5N1 has continued to spread around the world and is now too widespread to be eliminated. In addition, with increased spread there is greater potential for human exposure and for adaptation to human spread.

There is much speculation about the ability to cope with a future pandemic since medical science and the ability to care for the severely ill has improved since the 1918 pandemic. It was only in 1933 that the etiologic agent of influenza was discovered with it being the first human respiratory virus isolated and characterized. Advances in medical science have enabled those who are immunocompromised, chronically ill and older to live longer than in 1918. This means an even more vulnerable population will be exposed when another pandemic occurs.

In an effort to provide guidance in both preparing for a potential pandemic and as a means of establishing a warning mechanism, the World Health Organization has identified a series of pandemic influenza phases associated with increasing health risk. These phases are used throughout this plan to identify and link preparedness and response activities to those phases in which they are designed to occur. At the current time, based upon the identification of the H5N1 virus that has resulted and continues to result in human disease but has not shown the ability for sustained human-to-human transmission, we are in the Alert Period and Phase 3.

It is important to recognize that a given phase, such as that we are in now, may last for an indefinite period of time. It is also possible that transition through phases may progress at a very rapid pace depending upon the level of disease activity. There may also be return to a lesser phase, but it is unlikely that there will be a return to Phase 1 or 2 in the foreseeable future.

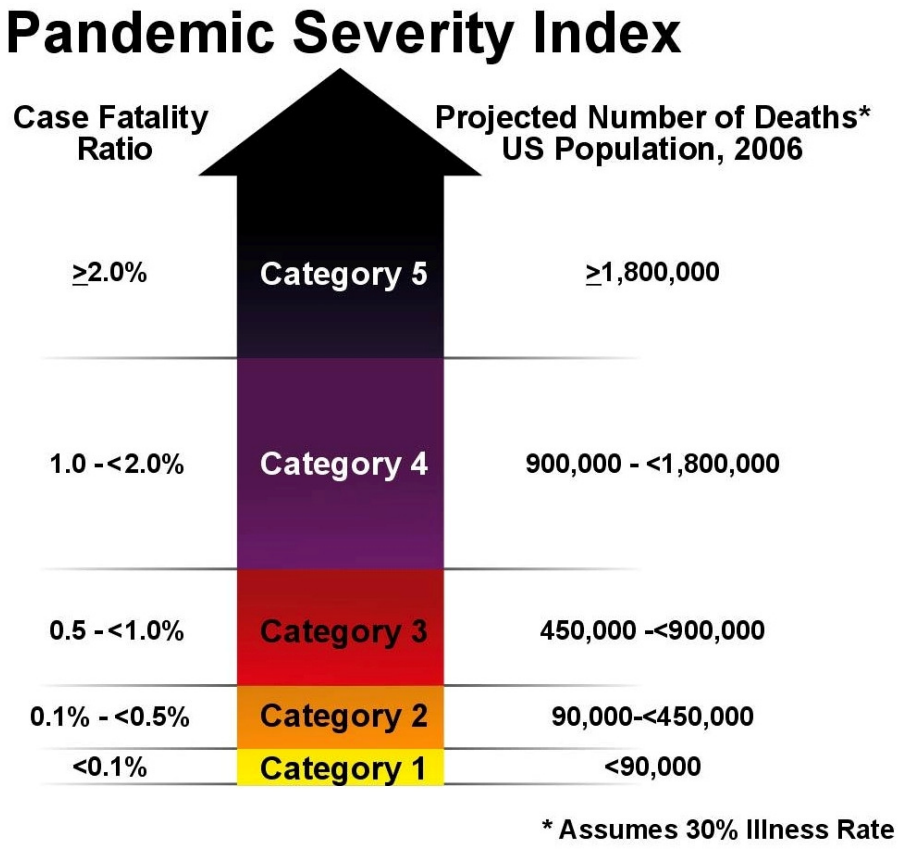
In addition, it is possible for the conditions in northern Idaho to be better or worse than those identified by the WHO phase at any given time, since the WHO determination is a global designation and is used as a gauge on which to base preparations as well as response.

World Health Organization Phases of Increasing Health Risk

Pandemic Phases	Overarching Public Health Goals
Interpandemic Period	
Phase 1: No new influenza virus subtypes detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered low.	Strengthen influenza pandemic preparedness at all levels.
Phase 2: No new influenza virus subtypes detected in humans. However, a circulating animal influenza virus subtype poses substantial risk of human disease.	Minimize the risk of transmission to humans; detect and report such transmission rapidly if it occurs.
Alert Period	
Phase 3: Human infection(s) are occurring with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.	Ensure rapid characterization of the new virus subtype and early detection, notification and response to additional cases.
Phase 4: Small cluster(s) of human infection with limited human-to-human transmission but spread is highly localized suggesting that the virus is not well adapted to humans.	Contain the new virus within limited foci or delay spread to gain time to implement preparedness measures, including vaccine development.
Phase 5 – Larger cluster(s) of human infection, but human-to-human spread is localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).	Maximize efforts to contain or delay spread to possibly avert a pandemic, and to gain time to implement response measures.
Pandemic Period	
Phase 6: Pandemic is declared. Increased and sustained transmission in the general population.	Minimize the impacts of the pandemic.

In defining an epidemic or, more globally, a pandemic, it is important to distinguish severity, not by the number of people who become ill, but by how severe the effect is on those who do get the disease. Every year from 5 percent to 20 percent of the population becomes ill with the seasonal variety of influenza, but for most the severity of illness is relatively mild. In a pandemic it is believed that about 30 percent of the population might become ill. What will distinguish pandemic illness is the severity of the disease for those who become sick. In order to provide estimates of magnitude, the Centers for Disease Control and Prevention has developed a Pandemic Severity Index patterned much like a

hurricane severity index, enabling projections of potential deaths associated with pandemics of varying severity. This will enable better communication with the public health community as to what to expect when and if a pandemic occurs.



B. Purpose and Goals

This plan provides guidance and procedures for the five counties that comprise the Panhandle Health District to provide for the health care of its citizens in the event that the capacity of the region's health care services is exceeded. Specifically, this plan is geared towards response to a pandemic influenza event as a worse case scenario. The plan details how, under severe and challenging conditions, those in need will receive the best health care possible.

In keeping with the mission of Panhandle Health District to prevent disease, disability and premature death, this plan focuses on prevention of disease and minimizing the morbidity and mortality of disease in the event that it occurs. Its focus is on providing the greatest benefit to the largest number possible, recognizing that it may not be possible or preferable to expend maximum amounts of limited resources for the benefit of single individuals. While maintenance of infrastructure and minimization of the economic impact on society are important considerations, within this plan they are considered secondary with significance mainly determined by their importance in maintaining or restoring community health.

C. Organization and Scope

The Panhandle Health District Pandemic Influenza Response Plan is one component of the Panhandle Health District Public Health Preparedness and Response Plan. As such, while some information may be duplicated for ease of access, this plan will refer the user for more in-depth information to the District's Preparedness and Response Plan, as well as, specific annexes of that plan such as:

Annex B. Public Health Emergency Risk Communications
Annex E. Epidemiology Surveillance and Response
Annex I. Isolation and Quarantine

This plan is designed along both structural and functional lines. In this way, even though it is not designed as a stand-alone plan, it is sufficiently organized so that those responsible for an identified structural component may be able to use the associated chapter of the plan and provided tools as a working document for the functions it is to perform.

This plan is also structured to provide actions to be performed consistent with the World Health Organization pandemic periods and phases defined above. These provide a framework to assist in organizing preparedness and performance expectations consistent with the situation occurring at any given time.

In addition, the plan considers the earlier illustrated Pandemic Severity Index developed by the Centers for Disease Control and Prevention. This is primarily a population-level tool, but provides a means of using severity assessment to guide determination of what mitigation interventions are appropriate.

The scope of this plan is to specifically encompass public health activities and those for which Panhandle Health is either wholly or in large part responsible. In recognition that a major proportion of necessary actions will be performed by organizations and agencies acting independently, this plan also provides guidance, tools and reference materials to assist those entities in their individual and coordinated planning.

II. ASSUMPTIONS AND CONSIDERATIONS

A. Assumptions

1. Northern Idaho will not be the location in which a novel influenza virus capable of sustained human-to-human transmission will be first identified.
2. Identification of a novel influenza virus at some other location in the world will provide weeks to months of advance warning before cases are first identified in northern Idaho.
3. An influenza pandemic will have widespread impact nationally and globally, limiting the amount of materiel and personnel support that would be available to northern Idaho. Resources may be limited to only those locally available at the start of the outbreak.
4. Idaho state authorities will provide declarative and legislative actions to facilitate the provision of care to large numbers of people.

5. Social distancing strategies aimed at reducing the spread of infection such as closing schools, community centers, and other public gathering points and canceling public events will likely be implemented during a pandemic requiring direct involvement of elected officials.
6. There will likely be significant disruption of public and privately owned critical infrastructure, including transportation, commerce, utilities, public safety and communications; therefore, planning for continuity of operations is essential.

B. Considerations

1. The severity and characteristics of a pandemic of influenza are impossible to reliably predict in advance of the emergence of the novel virus and epidemiologic assessment of the early cases caused by that virus.
2. Primary efforts will be toward the prevention of disease and minimizing the spread of disease to limit the breadth, duration and overall impact of the outbreak.
3. An effective vaccine will not be available early during the pandemic and once available will be in severely limited supply.
4. Prophylactic or therapeutic medications, if available at all, will be in limited supply.
5. The size of the pandemic and the lack of medical staff due to illness, may rapidly overwhelm the health care system.
6. Family and friends will provide the majority of care and support at home for those with illness.
7. Approximately 24% of persons would not have anyone to care for them, according to a national survey conducted by the Harvard School of Public Health (HSPH) Project on the Public and Biological Security.
8. An influenza outbreak will not be an isolated event with a second wave likely to occur in weeks to months after the initial outbreak.

III. LEGAL CONSIDERATIONS

A. National Laws

1. Governing Medical Care

Emergency Medical Treatment and Active Labor Act **(**EMTALA) - ***Any*** individual who comes to a hospital requesting an examination or treatment for a medical condition must receive an appropriate medical screening examination within the capability of the hospital's Emergency Department. EMTALA supersedes state laws for all facilities that receive funds from the federal government such as from MEDICARE.

2. Controlling Movement

Title 42 U.S.C., Section 264, provides authority to the Secretary of HHS to control movement of persons into and within the United States to prevent the spread of communicable disease.

Title 42 U.S.C. Section 70.2, provides that the CDC may take reasonable measures to prevent spread of disease between states.

B. State Statute

1. Authorities for Public Health Actions

Title 39, Health and Safety, Chapter 4, Public Health Districts, 39-414. POWERS AND DUTIES OF DISTRICT BOARD. Allows the district board of health "to do all things required for the preservation and protection of the public health and preventive health, and such other things delegated by the director of the state department of health and welfare or the director of the department of environmental quality and this shall be authority for the director(s) to so delegate."

Title 39, Health and Safety, Chapter 4, Public Health Districts, 39-415. QUARANTINE. The district board shall have the same authority, responsibility, powers, and duties in relation to the right of quarantine within the public health district as does the state.

2. Governing Medical Care

The State of Idaho Bureau of Homeland Security Emergency Operations Plan states "District Health Department Directors are responsible for directing regional emergency health and medical services following a major disaster emergency, or during a developing potential medical situation."

3. Protection From Liability

Title 39, Health and Safety, Chapter 77, Volunteer Health Care Provider Immunity, 39-7703. IMMUNITY FROM LIABILITY FOR HEALTH CARE PROVIDERS PROVIDING CHARITABLE MEDICAL CARE.
(1) Any health care provider who voluntarily provides needed medical or health care services to any person at a free medical clinic without compensation or the expectation of compensation due to the inability of such person to pay for the services shall be immune from liability for any civil action arising out of the provision of such medical or health services. This section shall not extend immunity to the health care provider for any acts constituting intentional, willful or grossly negligent conduct or to acts by a

health care provider which are outside the scope of practice authorized by the provider's licensure, certification or registration.
(2) Immunity pursuant to subsection (1) of this section shall apply only if the health care provider and the patient execute a written waiver in advance of the rendering of such medical services specifying that such services are provided without the expectation of compensation and that the health care provider shall be immune as specified herein.
(3) If a health care provider is insured for liability for negligent acts or omissions arising from providing health care services at a free clinic, the immunity provided in subsection (1) of this section is waived, provided however, the amount recovered shall not exceed the limits of such applicable insurance coverage.

IV. RESPONSIBILITIES

A. Businesses

Businesses have the need to sustain economic viability and also have a degree of obligation to protect the health of their employees and the public. In a pandemic, supply chain disruption, utilities failures and employee absenteeism will contribute greatly to the ability to successfully continue operations.

- Develop a Continuity of Operations Plan (COOP) (See checklist in Aids) to anticipate the requirements necessary to maintain business or to plan for a controlled scale-back.
- Businesses that involve public assembly will need to adjust for potential measures mandating closure or occupancy limitations.
- Businesses providing essential public supplies such as food, water, fuel, and medications will need to consider high demand, but also occupancy limitations.
- Plans should consider protocols to screen for sick workers and plans to send them home, policies to enable working from home when appropriate and office policies to encourage cough etiquette, hand washing and use of alcohol-based hand gels.
- Businesses may also play a direct role in public health support such as in providing sites for Community Assistance Centers, telephone help lines and as Alternative Influenza Care Centers.

B. City Governments

City governments should consider the imperatives of both continuing essential services and minimizing exposure to critical personnel.

- Develop COOP that enables maintaining essential emergency services while decreasing non-essential staff in central locations.
- Provide training on personal hygiene and cough etiquette to all personnel to decrease the risk of spread of disease.
- Provide training and Personal Protective Equipment to law enforcement and others that must remain in public contact during a pandemic.

- Assess for locations that might serve as Community Assistance Centers or Alternative Influenza Care Centers.

C. Local Colleges

North Idaho College and smaller facilities may be among the earliest required to curtail traditional classes and other group activities. Nontraditional venues such as distance learning may provide an avenue to continue services if personnel availability is sufficient. In addition, dormitories may provide an environment where spread of influenza may readily occur. Activities may include:

- Develop COOP to continue necessary operations and incorporate means to limit spread and consider dormitory residents.
- Instruct students and faculty on personal hygiene, cough etiquette and illness prevention.
- Consider a direct role in public health support, such as in providing sites and volunteers for Community Assistance Centers, telephone help lines and as Alternative Influenza Care Centers.

D. Community-based and Faith-based Organizations

While some formal activities may need to be curtailed during a pandemic, such as large community gatherings and church services, community organizations and faith-based organizations play key roles in support services for individuals and the community.

- Community-based and faith-based organizations will need to develop their own COOP.
- Consider operating and staffing Community Assistance Centers.
- Consider providing sites and volunteers for telephone help lines and Alternative Influenza Care Centers.

E. County Coroner/Medical Examiner

The Coroner will be responsible for planning for the disposition of an increased number of deceased persons and therefore not only will be unable to curtail operations in the event of a pandemic influenza, but must plan for increased operations over a prolonged period.

- Must develop a COOP to continue necessary operations despite a significant decrease in personnel.
- Develop a plan that considers the requirements in personnel, equipment and facilities associated with increased operations necessary during a pandemic.
- Arrange potential storage to maintain deceased remains for days to weeks while awaiting burial.

F. County Governments

Due to the primarily rural geography of the Idaho panhandle, county governments provide the majority of governmental services to the region. County governments are directly responsible, with the county Office of Emergency Management, for leadership, emergency support and coordination of services in each county, as well as regional coordination.

- Develop a COOP to maintain essential services, continuity of government and the health of employees and to adjust for potential personnel absences.
- Recruit, coordinate, oversee and support sufficient community and faith based organizations to operate Community Assistance Centers to provide resources to support care in the home.
- Assist in identifying possible facilities for Alternative Influenza Care Centers.
- If necessary, implement policies on movement restriction to limit disease spread
- Planning needs to consider roads and critical county services, such as social services, law enforcement and detention services.
- Become familiar with rationale and mechanisms of social distancing.
- County employees may be called on to serve as disaster workers as the need arises.

G. Emergency Medical Systems (EMS)/Pre-Hospital Responders

- Develop individual agency and cooperative COOP to maintain services despite diminished staffing.
- Will be responsible for prioritizing and providing patient transport in an environment requiring a surge due to increased demand.
- Provide training and Personal Protective Equipment necessary for heightened infection control practices by responders.

H. Fire Services

- Develop COOP addressing maintaining services despite increased personnel absenteeism.
- Provide training and Personal Protective Equipment necessary for heightened infection control practices by responders.
- May be asked to provide personnel and resources for disaster assistance as the need arises.

I. Idaho Department of Health and Welfare

- Ensure internal operations are maintained supportive of increased demands placed on District Health Departments.
- Serves as primary source of communication and information with national agencies such as the the Centers for Disease Control and Prevention.

- Coordinates request for and distribution of state and national assets such as state-purchased antiviral medications, nationally provided vaccines and the Strategic National Stockpile.
- Provides epidemiologic guidance consistent with the stages of the World Health Organization-declared pandemic levels.
- Provides updates on changes in prioritization criteria for use of antiviral medications and vaccines.
- Coordinates consistency of activities between Idaho health districts.
- Provides liaison assistance with state agencies in adjacent states and Canada.
- Coordinates activities with the state Bureau of Homeland Security.

J. Individual Residents and Families

Ultimately, individuals and families will have the most significant responsibilities during an influenza pandemic. They will be asked to disrupt normal behaviors and to adjust to great sacrifice in an effort to protect themselves and limit the spread of disease.

- Each family or individual should prepare pandemic influenza emergency kits enabling them to remain at home for periods of weeks at a time and to provide the majority of care in the home to those who become ill.
- Become educated and practice proper hygiene and cough etiquette to minimize the chance of acquiring and spreading an infection.
- Become and remain informed about the presence of communicable illness in the community through the use of media information and the Panhandle Health District website.
- Become familiar with social distancing and isolation measures they may be required to take.
- Make contingency plans for possible closure of daycare centers and schools.

K. Justice System

While the Panhandle Health District Director and the Board of Health are directly responsible for orders of isolation and quarantine, the court system will be responsible for adjudicating issues of enforcement ensuring the public has the benefit of due process rights protection. COOP planning should be a part of the parent governmental jurisdiction planning.

L. Law Enforcement

- Develop COOP to address both maintaining fundamental operations and the expansion that may be required despite an increase in personnel absenteeism.
- Responsible for providing enforcement of any health orders that are issued including isolation and quarantine.
- Responsible for enforcing orders on limitation of movement.
- Consider that social order may be more difficult when resources such as food become limited.

- Train personnel in personal hygiene and infection prevention.
- Provide and train on necessary Personal Protective Equipment.

M. Local Health Care System Partners (Hospitals, Clinics, Providers)

Health care system partners will be key in detecting influenza, limiting the spread of disease and providing treatment to affected individuals. Details are discussed in other parts of this plan, but briefly health care partners should:

- Develop individual pandemic influenza plans that provide for, as appropriate, continuity of operations; maximizing surge capacity to include opening and operating Alternative Influenza Care Facilities; credentialing of temporary staff; stockpiling medical supplies, food, water and fuel; and arranging for urgent additional medical equipment.
- In the event of a pandemic, conduct enhanced surveillance among patients, staff and visitors.
- Comply with public health directives for detecting, preventing and reporting cases of pandemic influenza.
- Maintain, and where indicated, improve infection control measures.
- Develop and provide education and training to staff on pandemic influenza.
- Coordinate consistent triage and admission guidelines with Panhandle Health and partner facilities/practitioners.
- Provide emergency and ongoing care.
- Provide estimates of quantities of vaccine and/or antivirals required for health care staff and patients and develop a vaccination plan for own facility.
- Plan for additional necessary site security for own facility.
- Further train personnel in personal hygiene and infection prevention.
- Provide and train on necessary Personal Protective Equipment.
- Develop plan for care of the deceased and assist in fatality management with guidance from the County Coroner.
- Participate in a North Idaho regional planning group for ongoing planning and coordination.

N. Mental Health

Mental health professionals will have key roles in providing psychosocial services to both the community and to responders who will be challenged by dealing with deaths among persons of all ages and the need to make decisions based upon limited availability of resources. Mental health professionals do not form a single body and therefore there is no single organization for which COOP planning can be performed.

- Each group or individual practice should develop its own individual COOP that will address operations under high levels of service demand and increased absenteeism of staff.
- Become further trained in infection prevention methods.
- Obtain training on the use of Personal Protective Equipment and obtain a preparatory supply..

- During any event, coordinate availability of services with Panhandle Health District.
- Consider, as individuals, joining the North Idaho Medical Reserve Corps.

O. News Media

The news media have a significant role in providing public information and education during the alert period, but will become an even more vital partner in health efforts during the pandemic period.

- Media organizations should develop a COOP to enable continued operations during a period of heightened activity, but potentially diminished staff.
- Train personnel in personal hygiene and infection prevention.
- Obtain training on the use of and provide necessary Personal Protective Equipment.
- Establish or continue relationships with health agencies in the District.
- During an event, coordinate with the Joint Information Center and/or individual agencies as appropriate.

P. Panhandle Health District

Panhandle Health District, as the only multi-jurisdictional health agency in northern Idaho has multiple roles during the alert period in planning for a potential pandemic influenza and would have a further heightened responsibility in the pandemic period. Roles include:

- Facilitating regional pandemic planning and preparedness efforts.
    - Providing information on pandemic influenza planning for both public and private entities.
    - Providing ongoing information on changes in conditions and new resources for planning.
    - Providing further consultation individually, as requested.
    - Coordinating planning efforts between agencies.
    - Developing and hosting exercises to further plan development and interagency cooperation.
- Educate the general public, community organizations, businesses, local governments and health partners about influenza and preventive measures.
- Facilitate regional disease surveillance efforts.
- Host and support the Panhandle Multi-Agency Coordination Group to coordinate care across the healthcare system and mutual aid between jurisdictions.
- In concert with governmental authorities, implement disease containment strategies, including isolation and quarantine, when they become necessary.
- Provide guidance and, when available, materials for immuno-prophylaxis or disease therapy.
- Request materiel from the Strategic National Stockpile, as indicated.

- Direct mass vaccination efforts when general use vaccine becomes available.
- Throughout the event, provide health information to the public and all partner agencies to include operating the Regional Telecommunications Center.
- Serve as the operational direction for overall community health efforts during the pandemic.

Q. Schools, Preschools, Child Care Centers, Family Day Care Providers

Schools and providers of care for children have important roles in planning for a potential influenza pandemic. Estimates are that infection rates in children could be as high as 40 percent in the event of a pandemic. Social contact leads to the potential for increased exposure and children provide an avenue for transmission to all other family members. Schools have the dual responsibility of ensuring education while potentially being among the first affected by decisions to curtail activities. Schools and child care providers should:

- Develop, as appropriate, COOP or closure plans.
- During the alert period, provide education to children, and through them families, on personal hygiene, cough etiquette and avoidance of going to school or work while sick.
- Develop contingency plans for continued education through distance learning and other means despite closure of facilities.
- Have well-developed communication with parents to enable rapid notification of developments.
- In the event of closure, school districts should consider making available facilities and other resources for Community Assistance Centers or Alternative Influenza Care Centers.

V. COMMAND, CONTROL AND COORDINATION

A. Components

1. Panhandle Multi-Agency Coordination Group

a. Purpose

Under circumstances in which this plan will be activated, agencies throughout the district will implement their internal plans and operate according to their individual processes; however, coordination of efforts and cross-organizational communication will be essential to maximize interoperability and the benefit to the community.

The Panhandle Multi-agency Coordination Group (PMACG), while not directly a command organization, will serve as the structure for interagency coordination, oversight and communication that will:

- Provide centralized coordination and monitoring of district-wide activities including healthcare system coordination
- Provide coordination of regionalized resources including Regional Telecommunications Center and Community Assistance Centers
- Issue regional situation reports on pandemic response activities
- Request and coordinate activation of residential care centers as additional bedded care facilities
- Provide centralized tracking of where beds remain available and the progress of bed expansion in regional facilities
- Enable consensus policy development and dissemination
- Provide an avenue for resolving interagency issues
- Enable central tracking of PMACG shared resources
- Provide for resource allocation decisions for joint use assets
- Establish coordination of public information
- Request, coordinate and respond to requests for mutual aid.

b. Organizational Structure

1) Agencies and Organizations Included

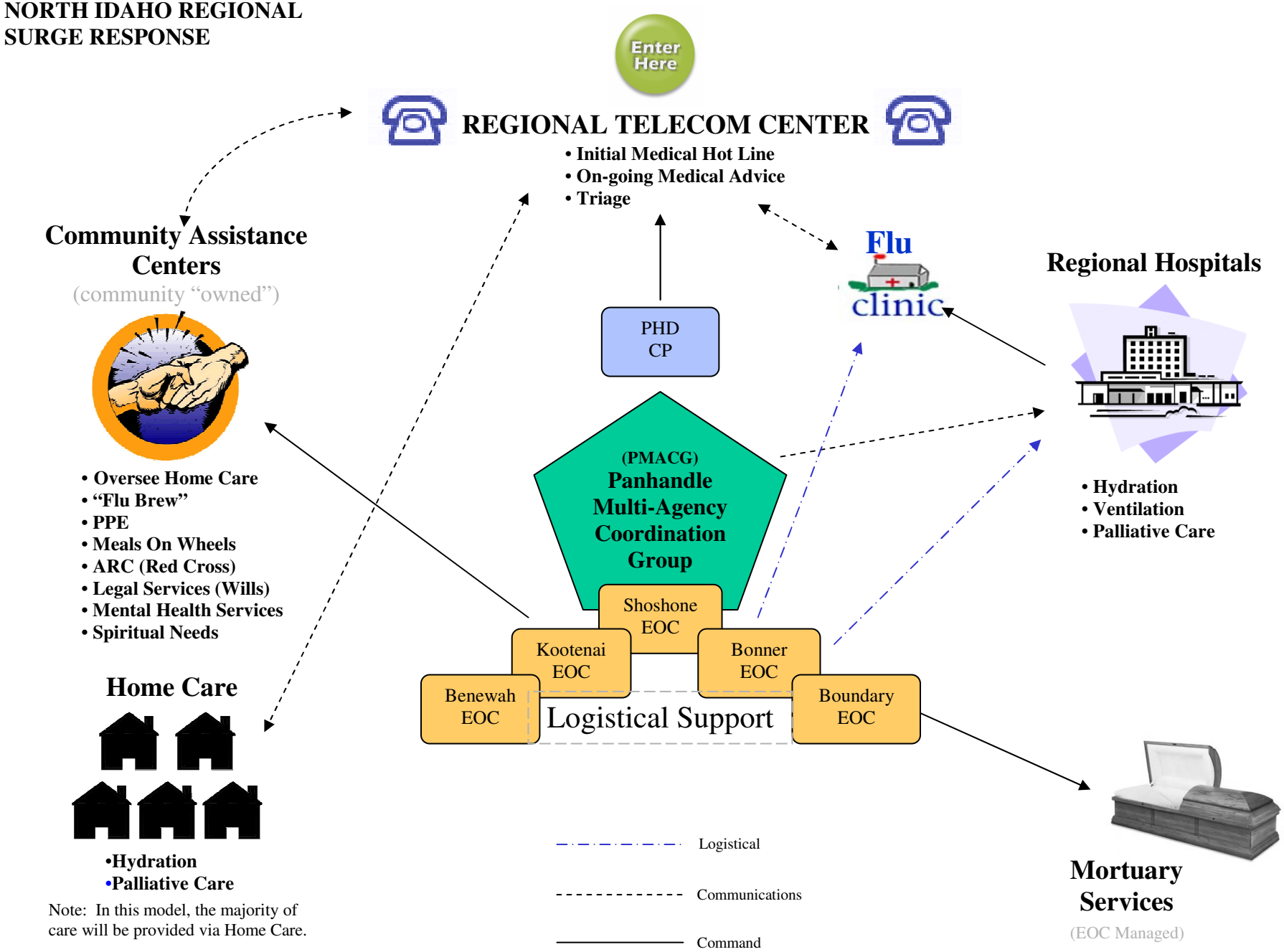
- Representatives of Benewah, Bonner, Boundary, Kootenai and Shoshone Counties
- Representatives of the Coeur d'Alene and Kootenai Tribes
- Panhandle Health District
- Representatives of:
    - Benewah Community Hospital
    - Bonner General Hospital
    - Boundary Community Hospital
    - Kootenai Medical Center
    - Northwest Specialty Hospital
    - North Idaho Advanced Care Hospital
    - Shoshone Medical Center
- Representatives of Immediate Care facilities

The PMACG will be chaired by the Panhandle Health District Director or designee.

c. Operational Center

The operational center for coordinated regional pandemic response will be the Panhandle Regional Coordination Center (PRCC) located at the Hayden office of the Panhandle Health District. Since a pandemic will occur over a matter of weeks rather than days, it may be impractical for there to be a standing PMACG

NORTH IDAHO REGIONAL SURGE RESPONSE



with members co-located at all times. The PMACG will be physically located at the PRCC, but member organizations that do not have representatives physically present may continue to attend "virtually" through telecommunication links on an as needed basis.

The PRCC will receive staffing and direction from the Panhandle Health District augmented by the North Idaho Central Type III Team.

d. Operational Actions

Since it is not anticipated that the PMACG will have direct, independent command authority, its role, as noted previously, will be as means of communicating and coordinating efforts throughout the region. While lacking command authority, it will be critical to ensuring that bidirectional flow of information is occurring and that decisions made are being implemented.

2. Panhandle Health District

a. Purpose

In accordance with County Emergency Operations Plans and specifically Emergency Support Function 8, it is expected that Panhandle Health District will serve as the lead agency in health-related crises. It has multi-jurisdictional responsibility in health matters and has been designated as incident command in health disasters.

While pandemic influenza provides a challenge far beyond expectations of most health disasters, the issues will remain health related. Decisions will be made in the context of the impact on morbidity and mortality with social and economic impacts strongly considered, but of secondary importance to life and death considerations.

b. Operational Responsibility

Panhandle Health District will serve as a participant and host of the PMACG, but will also serve as the operational command and control for regional coordinated health operations.

3. Emergency Operations Centers (EOC)

a. Purpose

In pandemic response, County Emergency Operations centers will form a critical support role both for non-medical and medical operations. In addition, the emergency managers form a vital link to both county government officials and to the State Bureau of Homeland Security and the State EOC.

The EOCs are not directly a part of incident command, but will provide county representatives to the PMACG as a critical part of regional coordination and will be directly responsible for a large amount of the non-medical logistical support of operations across the region.

EOCs will also be responsible for managing and supplying Community Assistance Centers within their jurisdictions.

B. Concept of Operations

(Agencies in parentheses have primary responsibilities for the functions noted)

Interpandemic and Alert Period

WHO Phase 1 and 2

a. Continued passive surveillance for seasonal influenza while educating the public about infection control measures
b. Develop and exercise public health preparedness plans for a range of emergencies while building the framework for community-wide cooperation

WHO Phase 3

a. Develop disease-specific planning for pandemic influenza (Panhandle Health District [PHD] and all health organizations as a minimum)
b. Familiarize members of the PMACG with elements of the plan (PHD)
c. Ensure development of Continuity of Operations plans by individual PMACG member organizations and other agencies (All)
d. Exercise and refine command, control and coordination procedures (All, PHD lead)
e. Determine current inventory of regional supplies and equipment available for a potential pandemic (All)
f. Perform a gap analysis of supplies and equipment on hand versus potential needs.
g. Stockpile medications locally for critical personnel (PHD, with other organizational input)
h. Determine list of potential sites for Alternative Influenza Care Centers (AICC) and Community Assistance Centers (CAC) (PMACG exercise led by PHD)
i. Initiate appropriate Memoranda of Agreement for potential locations of AICC (Hospitals) and CAC (Counties)
j. Begin to obtain additional stockpiles of non-perishable supplies and equipment based upon analysis in e. above (All)
k. Test bed notification capability (PHD Plans)
l. Distribute for review and revision initial patient care protocols (PHD Plans)

WHO Phase 4

a. Initiate regularly scheduled meetings of the PMACG
b. Identify groups that would potentially be willing to provide and/or staff Community Assistance Centers (County Emergency Operations Managers with assistance from PMACG)
c. Finalize Memoranda of Agreement with potential sites of AICC (Hospitals) and CAC (County Emergency Operations Managers)
d. Markedly increase stockpiling of supplies and equipment identified in the gap analysis (All members of PMACG)
e. Stockpile materials needed by CAC for home care. (Counties)
f. Provide PMACG-coordinated messages to the community to educate and prepare for a potential pandemic. (PMACG)
g. Coordinate and review initial patient triage and treatment protocols. (PMACG)
h. Provide increased education to healthcare providers regarding surveillance for unusual cases of influenza (PHD)

WHO Phase 5

a. Increase frequency of PMACG meetings and activities
b. Complete remaining readiness preparations for a pandemic outbreak (All PMACG)
c. Organize PRCC at Panhandle Health with limited staffing
d. Begin coordinated healthcare resource monitoring across the region (PMACG with PHD providing PRCC support)
e. Implement increased surveillance activities (All PMACG healthcare entities)
f. Increase the level of disease specific public education and preparedness encouragement (PMACG)
g. Provide education to organizations anticipated to establish CAC (PHD and Counties)
h. Relocate available medication supplies allocated for healthcare facility use to those facilities for further storage and initiation of use as directed (PHD)
i. Develop a finalized, updated list of telephone numbers, radio frequencies and email addresses for PMACG members and other key agencies (PHD)
j. Establish ongoing cross-jurisdictional communications with adjacent regions (PHD and Counties)

Pandemic Period

WHO Phase 6

a. Implement Pandemic Influenza Plan
b. Activate fully staffed PRCC operations (the actual level to be determined by current local conditions) (PHD)
c. PHD Director or designee assumes health incident command

d. PMACG to meet on schedule arranged, but with ongoing communication when not meeting.
e. Engage in active surveillance for arrival of novel influenza in the region. (All PMACG healthcare members)
f. As appropriate, PHD Director, with PMACG input if time permits, directs individual or family isolation.
g. PMACG as a group provides direct input to county governments and school districts on implementation of closures.
h. Provide active tracking and reporting of regional hospital and residential care facility bed availability status. (PMACG for input, PHD Plans for tracking)
i. Provide immunization for Tier 1A, if vaccine available.
j. Begin treatment of cases of illness in accordance with priority group designations provided by CDC through Panhandle Health and coordinated through the PMACG.
k. As conditions warrant, PMACG to make recommendations to member and external organizations on:
    - Implementation of bed expansion
    - Alteration in triage and treatment protocols
    - Implementation of CAC and AICC
l. Provide oversight of home care operations (All agencies involved in Home Care)
m. Identify need for additional resources
n. Provide financial tracking of PHD and PMACG related expenses (PHD Finance)

C. Communication

As previously noted, the PMACG will be physically housed at the Panhandle Health District building in Hayden, but many agencies will provide members to the PMACG through virtual means. Communications integrity will be an ongoing requirement and challenge.

Primary communications will be telephonic. For all members that have been connected to the PHD VOIP backbone, communication will be by VIOP due to potential crowding of other communication lines. Standard telecommunication, potentially overridden using GETS capability, will also be part of the primary telephonic communication network.

Communication of documents for review will be electronic via email, unless there is no internet connectivity, at which point information will be faxed.

Backup systems will be via radio, but it is not anticipated that this will be a primary means.

D. Expense Tracking and Reporting

Agencies operating under their individual plans and operating structures are responsible for tracking their expenses associated with pandemic influenza

activities. This applies even if the actions taken by member organizations occur as the result of PMACG recommendations.

Panhandle Health will have responsibility for tracking its own expenses, but will also track those specifically related to PMACG activities as an organized group.

E. Resource Tracking and Reporting

Agencies operating under their individual plans and operating structures are responsible for tracking their resources. No single regional database exists and will not be created since each organization has processes for acquiring and managing its own resources. PHD as a member organization and the region-wide operational arm of the PMACG, will be responsible for not only tracking its own resources, but as the organization responsible for requests to the State for SNS assets, will be responsible for tracking PMACG group resources that are designated to be shared across the region.

Member organizations will be responsible for identifying all resources (personnel, supplies and equipment) that they are identifying as potentially shared resources with other facilities and for identifying any shortfalls for which they are requesting community assets or requested State or Federal assets.

VI. SURVEILLANCE PROCESSES

A. Introduction

Surveillance for pandemic influenza and other infectious diseases is detailed in the Annex E, Epidemiology Surveillance and Response of the Panhandle Health District Preparedness and Response Plan. This synopsis is to merely provide a rapid overview of processes within the context of the World Health Organization pandemic phase framework.

In some respects, a severe influenza pandemic will provide some unique challenges since it has rapid spread, mimics multiple diseases including non-pandemic versions of influenza and is communicable before it manifests symptoms. These will all task those charged with surveillance to have heightened awareness and to be prepared to engage in an effort to project what is going to occur rather than merely react to what has occurred.

B. Concept of Operations

Interpandemic Period

Since, as previously identified from a worldwide perspective, we are currently in the Pandemic Alert Period Phase 3, the steps identified here apply in an ongoing fashion and would only be uniquely applied if the current situation were to resolve. Identified steps include:

a. Ongoing passive surveillance with collection of reports of adult and pediatric cases of influenza and influenza-like illnesses.

b. Ongoing laboratory surveillance for cases of influenza from specimens provided by sentinel providers.
c. Establishing plans for a network of heightened surveillance should the need increase

Pandemic Alert Period

Phase 3

Based upon the current presence of the H5N1 influenza virus in a form that can and has been transmitted to humans, but with only limited human-to-human spread in circumstances of extremely close contact, we are currently in Phase 3. During this phase, many of the heightened actions are at the international and federal level, but necessary current steps at the local level include:

a. Continued passive surveillance, but with heightened awareness of the possibility for a novel influenza virus.
b. Ongoing laboratory surveillance for cases of influenza through submissions by sentinel providers.
c. Communication with sentinel and other providers concerning the existence of a novel influenza virus identified by the World Health Organization and potential for importation through human travel.
d. Conduct a thorough evaluation of any off-season outbreaks of influenza-like illness.
e. Increase awareness of any influenza-related deaths
f. Ensure current plans are in place for increased detection capabilities and measures to control and limit spread.
g. Increase awareness of and communication with agencies that might identify an outbreak or the presence of suspected influenza in any poultry, bird, swine or other animal population in the state.

While the risk to northern Idaho is minimal, early identification is critical, and ensuring appropriate processes are in place is essential even at this phase. This is why it is still necessary to maintain surveillance and to aggressively investigate any non-seasonal or unusual seasonal outbreaks in humans to remain aware of the risks present in animal populations.

Phase 4

Defined as when small cluster(s) of human infection with limited human-to-human transmission have occurred someplace in the world, but are localized, the steps that will occur in this event are highly dependent on where in the world such clusters are identified. While this might occur as a primary event in northern Idaho, it is unlikely and in most cases there would be warning for the local community. If Phase 4 is reached based upon disease activity outside the western hemisphere, steps at the local level will continue to include:

a. Continued passive surveillance, but with heightened awareness of the possibility for a novel influenza virus.
b. Ongoing laboratory surveillance for cases of influenza through submissions by sentinel providers.
c. Communication with sentinel and other providers concerning the existence of a novel influenza virus identified by the World Health Organization and potential for importation through human travel.
d. Conduct a thorough evaluation of any off-season outbreaks of influenza-like illness.
e. Increase awareness of any influenza-related deaths
f. Ensure current plans are in place for increased detection capabilities and measures to control and limit spread.
g. Increase awareness of and communication with agencies that might identify an outbreak or the presence of suspected influenza in any poultry, bird, swine or other animal population in the state.

If the these clusters were to be identified within the United States or southern Canada, there would likely be additional guidance from the Centers for Disease Control, but efforts would be both to identify early any outbreaks locally with the intent to maximize efforts to contain or delay spread to possibly avert a pandemic, and to gain time to implement response measures.

Phase 5

This occurs when there are now larger cluster(s) of human infection, but human-to-human spread is localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible. The major efforts in such an event will remain at the international level or within the United States depending upon the location of the identified clusters. Local steps remain as those above, but the risk of a pandemic will be high at this point.

Pandemic Period – Phase 6

Once a pandemic is declared based upon activities worldwide, the likelihood of arrival in the United States would be a virtual certainty and in northern Idaho very likely. Steps at the local level in advance of the pandemic reaching the Idaho panhandle include:

a. Continued passive surveillance with heightened awareness of the possibility for a novel influenza virus.
b. Initiation of active surveillance as described in Annex E of the Panhandle Health District Preparedness and Response Plan.
c. Perform ongoing laboratory surveillance for cases of influenza through submissions by sentinel providers.
d. Maintain heightened laboratory surveillance through submission of samples from anyone having symptoms consistent with the definitions provided by the CDC.

e. Perform ongoing communication with all providers concerning the current status of the pandemic, diagnostic and treatment information, locations of cases thus far identified in the United States and any additional instructions.
f. Conduct a rapid evaluation of any outbreaks of influenza-like illness, to enable early instituting of control measures.
g. Perform ongoing and increased communication with agencies that might identify an outbreak or the presence of suspected influenza.

Once cases begin to occur in northern Idaho surveillance will be a significant tool in the initial identification of case distribution and the decision to implement measures to limit the spread of disease. Culturing and actual identification of the causative agent in individual cases will become of limited value as the outbreak progresses, but the epidemiological components of surveillance will remain important in identifying if control measures are effective and in identifying when the wave is abating. Further details are available in the Epidemiology Surveillance and Response Annex described above.

VII. MEASURES TO CONTAIN AND LIMIT SPREAD

A. Rationale for Community Measures

Initial efforts at minimizing the impact of pandemic influenza, or any other major infectious disease, on the northern Idaho community will include measures targeted at slowing the transmission of disease. While these efforts could ultimately have the effect of prolonging the outbreak within the community, such measures have the potential to decrease the number of individuals affected and enable the health care and other support systems in the community to cope with the number of those needing assistance since there may be fewer at any given time.

The value of any measures directed at slowing the transmission of disease directly depends on a successful surveillance program providing early identification that pandemic influenza has reached northern Idaho. Particularly in the case of a highly infectious disease and one that can be transmitted before the onset of symptoms, timing is critical. Control measures are detailed in the Panhandle Health District Preparedness and Response Plan, Annex I Isolation and Quarantine including the process for implementation. Relevant measures are only briefly addressed here and the reader is referred to the comprehensive document for more detail.

While first discussing community measures to slow the spread of disease, it must be recognized that these are essentially infection control measures, since influenza is primarily communicated through close personal contact. While some infections may occur due to contaminated surfaces, the majority of infections occur through exposure to droplets from an infected individual expelled through coughing. Sound infection control measures, as detailed elsewhere in this plan, should begin well before a pandemic occurs and should continue even when a pandemic is in progress. Infection control measures are applicable at any time and will prevent the spread of disease of all types. These social measures are

one means of directed infection control instituted for the benefit of the entire community, as well as individuals.

The timing and degree to which measures are implemented are based on information concerning:

- Case and contacts number of cases (absolute or estimated)
- Age of cases
- Location of cases
- Estimated number of work, school, daycare or other social contacts per case
- Rate of incident cases
- Number of hospitalized cases
- Morbidity
- Number and percentage of cases with no identified epidemiologic link
- Number of cases occurring among contacts
- Ability to rapidly trace contacts (#untraced/interviewed contacts)
- Ability to implement and monitor quarantine (staff member to contact ratio)
- Ability to provide essential services
- Community cooperation, mobility and compliance
- Degree of compliance with facility quarantine
- Degree of compliance with active surveillance and voluntary individual isolation
- Degree of movement out of the community
- Degree of compliance with community-containment measures

B. Social Distancing

These are measures designed to limit social contact to decrease the overall risk of infection in the community. Since influenza is contagious prior to the development of symptoms, persons able to spread the disease may still feel well and thus would unknowingly communicate the disease to others. Social distancing measures are aimed at limiting the number of circumstances under which this might occur.

1. Closing and cancelling schools and day care services at the first sign of pandemic influenza in the region including northern Idaho, eastern Washington and western Montana. This area may also include British Columbia if international borders have not already been closed to travel.
2. Cancelling events where large crowds would gather in close contact including sporting events, concerts, church services and community events.
3. Advocate implementation of public and private Continuity of Operations Plans providing for the ability to work remotely or create appropriate distancing at work.
4. In places where gathering is inherently required, such as hospitals, provide greater distancing in waiting rooms and segregate the evidently sick from those presenting for other reasons.

5. A degree of personal distancing can also be obtained by recommending that, when in public, individuals wear masks including places such as hospital waiting rooms, stores, etc.

Interpandemic and Alert Period

a. Verify existing legal authority and procedures are in place to implement social distancing actions.
b. Ensure all potentially affected agencies are informed about measures that might need to be taken, the process by which this will occur and any decision appeal processes that might exist.
c. Educate the public and media outlets about the types of steps that might be required and avenues that exist to get questions answered.

Pandemic Period

a. The Director, Panhandle Health determines the need for social distancing measures and level of restriction on movement necessary to reduce the spread of disease transmission.
b. If time allows, get formal approval of actions from the District Board of Health.
c. Coordinate with county governments the actions that need to be taken. (This is a coordination step and support should attempt to be gained particularly because PHD has no independent enforcement authority, but in health emergencies the District has statutory authority for direct action.)
d. Public Information Officer implements systems of communications for delivering relevant messages.
e. As appropriate, initial measures may be focused in an effort to provide local control.
f. At any time community-wide measures to reduce personal interactions within a targeted geographical region may be required.
g. Law enforcement assists with enforcement of actions as necessary and available.

C. Voluntary Isolation

Voluntary isolation of infected individuals within their homes is one way to limit the spread of disease to others. Additionally, advocating and permitting individuals and families to remain at home as much as possible may also limit spread of disease since it decreases or eliminates the risk of exposure. These measures are expected to be most effective during the later phases of the pandemic alert period and very early during the pandemic period because they typically work best when there are very limited numbers of persons infected. Its value is limited, however, due to the communicability of the disease prior to the onset of symptoms.

Isolation is defined as separation of infected persons from other persons for the period of communicability in such places and under such conditions as will prevent the transmission of the infectious agent. The success of these efforts will also be limited by the availability of basic necessities of living to these individuals and families. Preparation by individuals and families for such a potentiality should be encouraged well in advance and mechanisms developed to facilitate to ease of acquisition of additional necessities should they be required.

D. Forced Isolation/Quarantine

The forced isolation of individuals or quarantining of facilities will not likely play a large role in the event of an influenza pandemic. Its effectiveness will be severely limited by several factors including the nature of the disease itself in which those who are initially infectious are asymptomatic and therefore not identifiable and by the practical issues associated with force isolation and quarantine such as the reticence to take legal action and the need for enforcement.

Only in the case in which influenza-like illness is identified in a defined group such as the passengers and crew of a specific airplane would this method have a significant potential for success and this only if identification occurs before they have an opportunity for significant mixture with the community population.

E. Travel Restrictions

In general, imposed travel restrictions into and out of areas of the District may be both impractical and unenforceable. With the exception of the international border between the United States and Canada, there are few controllable points of entry. No major air or water port of entry exists within the District and highway travel is essential for ensuring adequate local supplies of necessities. There is a high level of daily travel between Spokane and the Post Falls/Coeur d'Alene area, as well as along the remainder of the I-90 and I-95 corridors. Efforts at travel restrictions will necessarily be voluntary and instituted through an active public information campaign.

VIII. PUBLIC COMMUNICATION AND EDUCATION

A. Overview

Effective communication with the public prior to and during an influenza pandemic will be critically important if authorities are to gain cooperation for needed social distancing measures, panic is to be prevented, psychosocial trauma is to be minimized and health care is to be optimized. Key to this process is early and frequent communication through multiple modalities.

In general, the public wants to know:

1. What happened/is happening?
2. What may/will affect me?
3. What can I do to protect myself and my family?
4. Who/What caused this?
5. Can you fix it?
6. Who is in charge?
7. Has this been contained?

8. Are victims being helped?

9. What can I expect, right now and later?
10. What should we do?

B. Purpose

Panhandle Health District has an extensive communications plan found in the Panhandle Health District Preparedness and Response Plan, Annex B Public Health Emergency Risk Communications. This section is designed to provide additional information to augment the existing plan and, in its accompanying appendix, to provide reference material for use in the event of an influenza pandemic.

C. Concept of Operations

This is really a function of what is defined in the annex on Public Health Risk Communications, but relative to the WHO Pandemic Plan Phases:

Interpandemic and Early Alert Period (Phases 3 and 4)

1. Develop key messages for printed materials, public presentations, or for the news media on influenza education, infection prevention, personal and organizational preparations for a pandemic and Panhandle Health and other public agency preparation efforts.
2. Provide annual messages to the public on encouraging seasonal influenza immunization, on respiratory etiquette and hand washing to prevent disease.
3. Provide media information as questions occur.

Late Alert Period (Phase 5)

1. Conduct a public education and awareness campaign to stimulate preparation and to manage expectations. Include messages on:
    a. Continuing to get the seasonal influenza immunization. Emphasize that it may not directly protect against a novel influenza virus, but it will help health care providers in eliminating seasonal flu as a cause of symptoms if someone should become ill.
    b. Home and personal preparedness including obtaining food, medications and other necessities.
    c. Actions to take in preventing infection.
    d. Education on the potential social distancing measures that might need to be imposed by authorities in the event of a pandemic.
2. Begin media information briefings on the state of preparedness and key messages on public preparedness and infection prevention (to include the above items).
3. Direct the public to the Panhandle Health District website and maintain current information that is readily accessible.

Pandemic Period

1. Reaffirm the messages provided in the late alert period.
2. Update and further develop key messages as appropriate.
3. Implement the Regional Hotline providing scripts for operators and answers to frequently asked questions.
4. Coordinate messages with other agencies either informally or through a Joint Information Center.
5. Conduct regular media briefings at a frequency appropriate to occurring developments.
6. Post materials to the Panhandle Health website as they are developed.

IX. REGIONAL TELECOMMUNICATIONS CENTER

During a pandemic, it will be critical that there exist a telephonic avenue whereby persons might receive individual advice and guidance if there is an expectation that most people will remain at home. In addition, an advice line may provide a valuable means of ensuring that self-treatment opportunities are maximized and that seeking of professional health care is appropriate when the need arises.

Panhandle Health District has an existing plan for a telephone hotline as a part of Annex B, Emergency Risk Communications of the Preparedness and Response Plan. This chapter of the Pandemic Influenza Plan captures the major concepts of that plan with a focus more specifically on influenza.

A. Initial Medical Hot Line

Panhandle Health District's Medical Hotline is designed to provide information and advice. It is not designed to provide medical care or to substitute for medical care. The medical hotline will be activated in time of an emergency when the telephone call load overwhelms PHD's current ability to respond. The decision to activate the medical hotline will be made by the incident commander in consultation with the command staff.

Once the decision is made to activate the medical hotline, the Public Information Officer will alert the hotline manager in the Health Promotion Division and the IT manager that the hotline is to be activated. The Health Promotion Division is responsible for staffing the PHD hotline. The IT department is responsible for setting up telephones and computers for hotline operators.

1. Responsibilities

a. Public Information Officer

- Overall direction of hotline/call center operations
- Script development
- Liaison between the hotline and incident command

b. Public Information Team

- Develop script

- Coordinate script contents through the PMACG to participating health organizations for consistency, currency and accuracy.

c. Health Promotions Division

- Staff the hotline/call center
- Provide manuals and operational materials to operators
- Provide just-in-time training to operator staff

d. Hotline Nursing Staff

- Provide consultation to hotline staff
- Accept referral calls for medical questions not addressed by prepared scripts
- Provide input to the Public Information Team on additions and corrections to the script based upon calls received

e. Hotline Mental Health Staff

- Provide consultation to hotline staff
- Accept referral calls for mental health questions not addressed by prepared scripts
- Provide input to the Public Information Team on additions and corrections to the script based upon calls received

f. PHD Information Technology

- Phone system set up and maintenance

2. Concept of Operations

Current PHD plans call for the hotline to be set up in the computer training room on the first floor of the Panhandle Health building in Hayden. This space will only allow a limited number of phones to be operated and this is further complicated by the need to maintain distance between operators to minimize the possibility of spread from an asymptomatic individual infected with influenza.

Expansion of available lines will be based upon call volume and, depending upon technological capabilities, may be expanded to other single offices in the facility or to phones located remotely from the building. Regardless of where operations occur or how many lines are developed, hotline operations will remain under the overall direction of the Public Information Officer (PIO) and be operated by the Health Promotion Division.

Interpandemic Period - Phase 1 and 2

a. Design hotline operations
b. Exercise and refine hotline operations

Alert Period - Phase 3 and 4

a. Develop initial draft script for pandemic influenza
    1) Using CDC and other available information, a tentative script should be developed considering most major questions that would be anticipated early in an influenza pandemic
b. Disseminate script to health care partners for review and input

Alert Period - Phase 5

a. Refine the script in light of the highly likely characteristics of the novel influenza that is becoming more prevalent
b. Depending upon the number of calls received by PHD to this point, hotline operations may be initiated in a scaled-back form during this phase, otherwise operations will likely begin in the Pandemic Period

Pandemic Period – Phase 6

a. Hotline operations will begin at the direction of the Incident Commander
b. The PIO will verify that the draft script previously developed remains correct or will direct the PI Team on updated the script in coordination with appropriate agencies composing the PMACG.
c. PHD Information Technology will set up the telephone network and other infrastructure required to begin operations.
d. Health Promotions Division will select and schedule personnel to serve as hotline operators.
    1) Operators will work four-hour shifts and supervisors will work eight-hour shifts. If hotline operations extend to 24-hour periods, staffing will be weighted toward daytime and early evening operations.
    2) The Health Promotion Division will develop a staffing plan and provide staff to fill hotline positions.
    3) Hotline job action sheets are located in Appendix 7.3 of the Public Health Emergency Risk Communications annex to the Preparedness and Response Plan.
e. Health Promotions, with the assistance of FACH and the Medical Reserve Corps Coordinator will identify nursing staff (minimum one per shift) to serve as Hotline Nursing Staff
f. The Medical Reserve Corps Coordinator will identify mental health staff (minimum one per shift) to serve as Hotline Mental Health Staff.
g. The PIO will brief hotline operators on the script and anticipated frequently asked questions
h. PIO will provide a current list of available community resources, including established Community Assistance Centers to hotline operators.

i. PIO will provide the public with contact numbers for them to reach the hotline and the PHD website where FAQ will also be posted.
j. The PIO will inform county 911 centers (or the EOC, if activated) to inform them of hotline activation and provide a script as requested.
k. During operations, operators will collect unanswerable questions or ones that are frequently asked, but not contained on the script so that script updates can be done.
l. The Public Information Team will review the script at least each shift and update as needed.
m. Prior to the start of each shift, incoming operators will be briefed on the current script and their questions answered.

B. Ongoing Medical and Psychological Advice

While there may be limited trained personnel resources with which to provide medical and psychological advice, these may be key components to preventing the need for additional hospitalization or may simply enable individuals to endure a very challenging experience.

1. Medical Advice

Medical advice must be algorithm-based to ensure that such advice is consistent from person to person and in keeping with sound principles. While individuals may wish to help, if advice is not consistent with the above, it may cause harm and potentially leave the health district open to liability, however well meaning the advice may be.

Medical advice will fall into two broad categories with those being advice on self/family care and advice following triage on possibly seeking professional care. Triage is discussed later, but ongoing advice would include hydration, fever management, dietary counseling and supportive care. Some tools available to use are included in the appendix to this chapter.

2. Psychological Advice

Psychological advice will be a component of community psychological support and will be available to the public and to pandemic workers. The individuals providing support must be trained mental health professionals and should have significant experience in assisting persons with stress reactions. This care will not be protocol driven since it will vary significantly from person to person and it is not designed to be long-term therapy or a substitute for direct patient care between therapist and patient.

A key role of the hotline will be to provide information on available resources for those in acute need of psychiatric intervention. The hotline mental health professional may be able to provide a limited form of psychiatric triage, but ultimately those either deemed as worrisome or self

identifying as having an urgent need will need to be referred to an identified resource for acute care.

C. Medical Triage

One avenue by which patients will be directed to seek care will be through limited triage performed by hotline nurses. The precise protocols to be used will need to be developed when it becomes clearer how the pandemic influenza virus behaves, but a general triage protocol is included in the appendix to this chapter.

It must be remembered that triage under this circumstance is necessarily limited since the hotline only has the options of suggesting that someone stay home or direct them to a clinic or hospital, but is not able to provide them an appointment at that clinic or medical facility and therefore cannot guarantee care.

X. COMMUNITY ASSISTANCE CENTERS

A. Purpose

During an influenza pandemic, it is expected and planned that the majority of care will necessarily be provided within the homes of those having contracted the illness. In the event of social distancing measures, the need for isolation of infectious persons within their homes and the limited availability of knowledge and resources, some mechanism must be created to facilitate the opportunity for persons to remain at home and receive care either by family and friends or by professional caregivers. The Community Assistance Centers (CAC) will be developed primarily to provide the resources available in the community to support care in the home, but also to potentially provide additional family and individual support services.

B. Provided Services

While the primary intent of the CAC will be to provide support to those who are being cared for at home, other services may be available depending upon the organization involved and the resources available.

1. Provide and oversee home care
2. Provide supportive supplies
3. Provide basic nutritional and fluid support
4. Provide emotional and spiritual support
5. Provide information and assistance with administrative activities such as legal and decedent matters

C. Organization

1. Structure

The CAC are designed to be organized, staffed and operated by community and faith-based organizations. Many organizations have existing strong relationships with members of the community, structures

from which to operate and some may have pre-existing resources with which to assist.

In organizing a CAC, it must be kept in mind that a critical consideration is minimizing the spread of disease, so personal protective equipment should be worn in all circumstances of close contact. In addition, adequate space must be allowed to further decrease the likelihood of disease spread. This requires a minimum of three feet (ideally six feet) between persons so that tables, etc. should be large enough to allow this separation.

Since a person may be contagious prior to having symptoms, it cannot be assumed that if one feels or appears well that they cannot have the illness, so, while people should not be afraid to support one another, reasonable precautions should be taken.

There will be two primary structural models, but hybrids of the two may be created.

a. Drive-Through
   This model is designed to provide basic supplies which might include personal protective equipment, hydration supplies, packaged food and beverage items, personal care items and patient care information.

   This model, either alone or combined with the full-service model is designed to rapidly provide a potentially high volume of basic needs in a setting that will keep the possibility of infecting others to a minimum since clients never leave their vehicles and the exchange of materials is only one way. Preparation of materials can also involve a small number of persons and be tightly controlled to minimize the risk of infecting others.

b. Full-Service
   This model is more complex and may involve face to face interactions and/or telephone communications in addition to or instead of a drive-through type of service. In this case, it could include direct distribution of meals, provision of counseling services, legal support in preparation of wills and assisting in making arrangements for deceased loved ones.

The specific model to be used will be entirely at the discretion of the providing organization, however, while some public support may be available in obtaining supplies and educational material, personnel support and expertise in counseling, legal matters and other such services offered will need to be arranged by the organization itself.

2. Command and Control

Any organization planning/implementing a Community Assistance Center should contact their county Office of Emergency Management. While direct operations of the CAC will be at the organization level, this coordination with the County Office of Emergency Management will:

- Enable overall community awareness and coordination of where centers are.
- Assist the Regional Telecommunications Center in knowing where people may be referred for help.
- Identify organizations eligible for supplies when they become available through donations, government delivery or purchase by public agencies.

Elements of the Community Assistance Center should include:

a. Director

Responsible for overall direction of the CAC. This should be someone who is skilled at organization and communication, but who is not going to be directly responsible for performing client services. This would mean that if an individual is to be a primary part of providing ongoing counseling or spiritual support services, that individual may not have adequate time to both perform those functions and direct the CAC.

b. Liaison/Information Person

This person will be responsible for establishing and maintaining communications with Panhandle Health District and other outside agencies. They will also engage with the Panhandle Health District Public Information Officer to provide and obtain information for public release.

c. Operations Section Chief

This individual has responsibility for organizing and directing the internal operations of the CAC such as distribution of materials to clients, organization and operation of any home care services that are provided and operation of any telephone services,

d. Logistics Section Chief

This person will be responsible for obtaining and organizing resources to include supplies and personnel.

e. Finance Person

While the likelihood of public funds becoming available is limited, if funds became available, disbursement would be

based upon accurate accounting of expenses occurring directly in support of pandemic influenza support patients.

Each of these primary positions will organize persons into teams to perform functions outlined below. Further description of their responsibilities and how to perform tasks are contained in the appendix to this chapter.

3. Facilities

Any number of or combination of facilities may be used to provide a CAC, depending upon the services to be provided. Many organizations, such as faith-based organizations, have existing structures. These are of varied configuration and may have large common areas, classrooms and large parking lots. Some even have on site cooking facilities. These are ideally suited for the full service type of model if significant separation space can be provided. Other facilities are more limited and some organizations may need to borrow facilities. A facility lay-out is difficult to define since each will vary, but key elements may include:

a. Command and control area
b. Supply storage area
c. Materials preparation area/s
d. Home care support kit assembly area
e. Distribution area (may be in parking lot)
f. Meal preparation area
g. Telephone calling area
h. Personal interview area
i.. Staff rest area
j. Restroom facilities

The functions of each are discussed in greater detail under Concept of Operations.

For some organizations, an ideal distribution site might be a closed fast food restaurant with a drive-through. This provides an environment in which the packet distributor is sheltered from the elements, protected from clients who might be insistent upon receiving more than their fair share and protected by some distance from clients who might be infected. In addition, such locations have bathroom availability, multiple sinks for hand cleaning and clean/cleanable surfaces for preparation of “flu brew” packets and home care support kits.

D. Personnel

1. Staffing

The absolute number of staff required will depend upon the mission the CAC has determined to be appropriate, but as a general model staffing considerations should include, in addition to those described above:

a. For each materials distribution station
    - One person to hand out materials
    - One to restock materials
b. For the distribution area
    - One or more to control flow
    - One or more to ensure order/security
c. For home care support kit preparation area
    - Three or more packet assembly persons
    - Two or more persons to restock assembly supplies
d. For supply area
    - One or more to receive and break down supplies
    - One to keep inventory on available supplies
    - One or more to ready supplies for the preparation area
e. "Flu brew" packet preparation area (note counties may decide to prepare these in a central location to ensure consistency)
    - Minimum of two people for packet preparation
f. Transporters to move supplies and kits to appropriate locations
g. Personnel to set up shelters for parking lot staff, place signage, etc.
h. A person to hand out personal protective equipment to staff and clients (if a walk-in facility) and instruct on its proper use
i. At least two security personnel to ensure security of materials and that staff are not coerced into giving clients more than is appropriate for each.
j. Other staff will depend upon the range of services offered by each CAC.
k. Personnel to provide or support provision of home care, if the organization accepts that as part of its mission

The number of distribution stations will depend on expected volume, the size of the available distribution area, potential traffic patterns and the availability of supplies. As a result, there will be no set number per organization or facility.

2. Personal and Environmental Protection

In an environment in which persons are being urged to stay at home, organizations that establish CAC and the individuals willing to come forth and provide support are both assuming increased risk of acquiring and spreading disease. By creating gathering places organizations are creating the circumstances under which spread can occur. Individuals may unknowingly spread the disease in their desire to help if they are asymptomatic spreaders and those coming to help may be placed at risk by other workers or by the clients seeking help. Because of these circumstances, protection and infection control efforts are critical.

a. Personal Protection
Wearing a mask and gloves is recommended any time one is within close (3 feet or closer) contact with others and when one is preparing materials to be handed out to others. Further protection is likely unnecessary, but final guidance will need to occur after the behavior of the actual virus responsible for the pandemic is defined. If gloves are not worn, frequent hand washing or use of alcohol-based hand gel must be performed and is absolutely essential before a person gets their hands in the proximity of their eyes or nose. Hand-shaking as a form of greeting should be avoided.

b. Environmental Protection
Influenza virus is known to survive on surfaces with the time of viability determined by the surface involved and environmental conditions. Despite this, it is unclear if the virus can be contracted in this way. Even if infection can occur this way it is not the primary way that infection occurs.

It is primarily due to this possibility that it is advised that gloves are worn. In addition, surfaces used for preparation of materials to be given to others should be cleaned before and after use. A simple household spray cleaner is adequate. Regardless of the presence or absence of influenza, this is a generally sound practice.

E. Concept of Operations

Actual operations will vary depending upon the services to be offered and the facility used, however, there will be some common practices and procedures used.

Facility selection has been initially discussed above and may simply be the use of an organizationally-owned facility or may involve borrowing of another location such as a fast food restaurant. Personnel should initially determine how flow will occur external to the building as well as internally. Flow should allow for spacing between people working to minimize crowding of workers or clients to decrease infection risk. Signage must be prepared both to direct staff and clients.

1. Setting Up

a. Command and Control

A command and control location needs to be established. This will be the center of operations, from which internal and external communications will occur, record-keeping will be done, supply requests will be received and acted upon, coordination of any direct home care efforts performed and operational decisions made.

The selected location should have telephone lines, computer capability, photocopying capability and preferably should include some meeting space in which needed gatherings can occur.

b. Supplies

It will be necessary to establish a location where supplies can be received, broken down into usable amounts and stored. Suggested basic supplies are detailed in the appendix, but it will be necessary to estimate the maximum requirement needed and to ensure that there is either initial storage space for a large amount of materials or that there is a means of ensuring replenishment as needed. The space needed for this purpose will be the largest single use indoor space requirement.

Supplies must be acquired or developed on site. Supplies that CAC organizations cannot obtain or create (such as educational material handouts) on their own should be requested through the appropriate county Office of Emergency Management.

Stored supplies should be grouped by purpose such that items that go together in making “flu brew” are co-located, etc.

c.. Materials Preparation

A designated area will be required for assembling home care kits to be handed out. This should be close to or may actually be co-located with the supply area to facilitate transport. If the amount of supplies stored on site at any one time is relatively small, home care kits may be assembled directly from the stored stock in an assembly line fashion.

Assembly of standardized kits must occur well before CAC operations begin since a large number of kits will be required and the organization will wish to avoid running out while distribution operations are in progress.

d. “Flu Brew” Preparation

Ideally there would be an ample supply of bottled fluids such as sports drinks and pediatric solution or commercially prepared packets of “Gatorade” type solutions that could be distributed to ensure that persons would get balanced fluids if they were otherwise at risk of not getting proper nutrition and fluids.

If this is not the case, it may be necessary to prepare mixtures of the appropriate ingredients to distribute for home use. Ingredients are detailed in the appendix. It is very important

that the correct proportion is maintained in the mixture in order to prevent unintended adverse reactions. Packets will be prepared in a standardized recipe and packaged in such a way that a packet will be added to a standard volume of water to create an appropriate solution. Flavoring agents may be added or made available to make the solution more palatable.

e. Facility Organization

In preparation for opening services, signage will need to be created and placed to direct staff volunteers and clients. External signage should designate staff parking areas, staff entry areas to the building, client parking and entry areas (if applicable) and traffic flow for parking lot distribution sites. Internally signage should designate each of the functional areas and should direct clients to provided services if made available.

In addition to distribution of masks and hand gel to individual staff members at entry and masks to clients, additional masks, gloves and hand gel should be positioned throughout the facility to encourage use. Ensure restroom facilities are amply supplied with soap as well as placing alcohol gel in any staff break rooms.

If client services are to be offered, adequate separation of areas should be ensured. One way to do this is to have individualized rooms or screened off areas to provide both protection and privacy for clients.

g. Distribution

Whether in the form of an existing drive through or a developed capability in a parking lot, it will be necessary to provide a table, box or other platform to hold the kits being provided. If a parking lot is used, some protective covering should be erected for those handing out kits. The location of the distribution areas should be easily accessible by car, but should also limit the distance transporters will need to carry kits to supply the distributor. In addition, the flow pattern for cars should allow easy one-way flow, preferably with the entry and the exit from the parking lot by different routes.

h. Meal Preparation

Food preparation will be a variable component of CAC. In most cases, if food is being provided to support clients remaining at home, it should be prepackaged commercial meals. In a prolonged event, prepackaged meals may be unavailable and organizations, such as church groups, may elect to take meals to the sick. These may be prepared in people's homes or at a facility kitchen, but the same rules apply relative to wearing

masks and gloves to prevent contamination. It must also be kept in mind that other foodborne illnesses are also a risk and must be guarded against.

i. Telephone Calling

Facilities will likely want to consider having some type of help line in case persons have questions about operating hours, instructions provided in the home care kits, or about how to contact resources to get a further level of care.

Those organizations engaging in direct provision of home care services will also need a communication infrastructure to enable caregivers to call to arrange for replacement supplies and to get further information.

This service can be provided through use of existing offices and telephone numbers within the organization. It is unlikely that resources will be available to develop new capability at the time of a pandemic.

j. Additional Personal Services

Organizations that have mental health expertise available may offer support either in person or via telephone. Legal services may be available such as preparation of individual's Last Will and Testament. Other organizations inherently offer spiritual support.

If these services are offered in person, provision must be made for access by clients, spacing of individuals and infection control measures. Privacy should also be considered. Where possible the following should be observed:

- The entrance by clients should be a separate entrance from that used by staff.
- Upon entry all should be offered a mask to both protect themselves and others.
- Shaking of hands should be discouraged, but it should also be explained why this is important so as not to offend those who may already be suffering significant stress.
- If possible, clients should be scheduled rather than served as walk-ins to minimize the number of persons present at any time and to avoid lines.
- Individual offices or classrooms should be used, if available with a table across which speaking occurs or a separation of over three feet (ideally six feet) maintained.

- If a common area must be used, tables should be set up with no less than six feet between them and privacy curtains erected, if possible.

It is recognized that the wearing of masks and the maintaining of separation is a double precaution, whereas each might be effective alone, but the protection of workers and continued availability of their expertise is vitally important to continued successful operations.

k. A staff rest area and adequate restrooms need to be available.

2. Direct Home Care

A few organizations may have the volunteers, resources and desire to provide direct home care services for those who have no one else to care for them. Since professional expertise is likely to be limited by the need for these personnel at hospitals, alternative influenza care centers, clinics and other locations where more definitive care is being provided, the level of care that can be provided will likely be limited and will mostly be supportive.

Services provided will vary, but might involve:

- Delivery and assistance with hydration
- Delivery of meals
- Personal care for those too weak to provide for themselves
- Delivery of medications
- Assistance to families if someone has died

Since care will be, by definition, delivered to infected individuals and contact will be close, it will be important for staff to wear mask, gloves, a paper covering gown and, where possible, glasses to prevent infection of mucous membranes. Even after the wear of gloves, alcohol hand gel should be used.

Resource documents for home care are provided in the appendix.

3. Operations

As personnel arrive to serve at the CAC, they should immediately be provided with a face mask and alcohol hand gel. Frequent use of gel should be encouraged. They should be signed in and provided with name tags. Signing in enables both identification of who is present to serve and also provides documentation of who was present if it later becomes necessary to contact personnel about possible infection.

Provide orientation and initial training to volunteers. Training should include not just methods of operation, but should focus strongly on infection prevention.

Some organizations will provide services primarily to a select community. These will advertise service opening through telephone contact or other defined means, but those that will provide general community services may utilize public announcement through contact with the county Emergency Operations Center and Panhandle Health District.

Kits are designed to be distributed to households with ill individuals and typically will serve to augment preparations that the family has itself put into place. It is not designed as a substitute for family or personal action. It will likely be impossible for an organization to provide total support for a large number of individuals for an indefinite time.

A kit should be distributed for each ill person in a household since it is designed to provide essential fluids and other materials for that individual as well as protection for other family members. Distributors should wear masks to prevent exposure from those in vehicles.

Remaining operations will depend upon the services rendered as described above.

Each CAC should keep the county Emergency Operations Center informed of its status on a regular basis.

4. Re-supply

An organization may need to rely to a significant degree upon its own resources, but will engage with the county Office of Emergency Management and the activated Emergency Operations Center to request additional supplies.

XI. HOSPITAL CARE

The capacity of the health care system in Northern Idaho is limited. Under normal circumstances, requirements that exceed local capabilities would be met by referral to the Spokane, Washington metropolitan area; however, it is a virtual certainty that a communicable illness, such as influenza, affecting North Idaho will be simultaneously widespread in Eastern Washington and will heavily impact the medical system in Spokane rendering it of limited assistance. The ability of our health care system to develop a coordinated strategy to prepare and ultimately to provide care for pandemic influenza patients is critical to minimizing the impact of such an event on the people and economy of North Idaho.

The occurrence of the next pandemic is currently impossible to predict with any accuracy. Its rapidity of onset, severity and the extent of disease in other locations, particularly in the western United States, will markedly affect the approach we will need to take and the degree to which we can expect any materiel support from adjacent, state or Federal resources. As a practical matter, we must assume absent or very limited support under most scenarios that are likely to occur.

In recognition of this, all hospitals should consider scenarios in which:

- Under normal operating circumstances, they will care for a limited number of persons with pandemic influenza.
- A transition will be needed to care for an overwhelming increase in the number of patients with pandemic influenza while maintaining other acute care capabilities.
- Care burden may require an altered standard of care and use of novel care locations

This plan is not intended to substitute for institution-specific pandemic influenza/infectious disease plans. Each facility has unique capabilities and requirements and each serves a somewhat different community. This plan is designed to provide assistance in facility preparation of their individual plans and to provide for regional and cross-discipline coordination of efforts.

A. Regional Objectives and Coordination

Regardless of the local community served, there are several overarching objectives that apply if the impact on any given community is to be minimized.

1. Objectives

a. Coordination of care planning must occur well in advance of the occurrence of any event for which such plans might be needed.

While plans themselves often will require modification at the time of an actual event, the process of planning and coordination of efforts between facilities well in advance of any acute need establish key contacts, facilitate common understanding and expectations and enable identification of recognizable shortfalls that can then be addressed.

b. Identification of suspected disease cases must occur as early as possible and information shared to enable immediate activation of a coordinated regional response.

While there are several agencies that have a level of responsibility in disease detection, the earliest cases are likely to be identified in individual health care provider offices, urgent care clinics and hospital emergency departments. Once the WHO Alert Period, Phase 5 is reached, the index of suspicion must be increased in order to improve the likelihood of early identification. It is only through this early detection that efforts to limit spread will be most effective.

c. Health care services must be maintained at a level that provides for continuing care of other urgent health care requirements while enabling the greatest amount of care for those presenting with severe pandemic influenza needs.

While the demand for influenza-related services will dramatically increase during a pandemic and the request for elective services will likely decrease, the level of required services related to injuries, childbirth and chronic care will likely not change significantly. While resources will be diverted in the care of infectious disease patients, sufficient capability must be maintained to meet ongoing patient care requirements.

d. Efforts will be focused on providing survival for the greatest number of individuals over the needs of single individuals.

Under normal circumstances, the absolute availability of resources is not a limiting step in the ability to provide care for an individual or group of individuals since the workload is either directly manageable, additional supplies can readily be obtained or patients may be transferred to facilities in which there are greater capabilities. This will not likely be the case during a pandemic in which supplies will be in short supply, personnel will be absent and the number of patients may be overwhelming. This situation will require the application of triage protocols and resource decisions that will change as the severity of the pandemic changes. As a result, some who might have otherwise received limited resources, such as ventilators, may not have the survival likelihood that another might have if the same limited resource were to be used.

e. Hospital acute care beds must only be used for those requiring a highly acute level of care while other mechanisms must be developed to provide for those patients that can be cared for in other settings.

Acute care hospital beds will be rate limiting in the event of a severe pandemic and must be carefully used only for those who can receive the greatest benefit and who cannot be provided a reasonable degree of care otherwise. Alternative settings will need to be utilized to provide the majority of care and to provide for a potentially controlled avenue for entrance to and, in some cases, discharge from hospital beds.

f. Coordination of efforts will occur between facilities to:
    1) Decrease inconsistencies in care from facility to facility.
    2) Limit population shifts to take advantage of differential services in one location over another.
    3) Avoid resource shortfalls in a given area.

Consistency in care across the region would quickly become a source of public concern and might lead to persons seeking care at a neighboring area assuming or knowing that they would receive more services than if they were cared for in their local area. Inherently there are differences in the capability of

facilities in the Panhandle Region, but if common protocols are used uniform expectations will be maintained.

g. Decisions and actions should be as transparent as practical and consistent with national and state guidance and the best scientific and medical information available at the time.

   Difficult triage decisions may be necessary in the event of a severe influenza pandemic. Utilization of common guidelines and protocols that are consistent with national norms whenever possible and understandable to the public will both facilitate compliance and prevent potential civil unrest.

h. Actions taken during the event must be supportable and enable the confidence in health care system and institutions to remain following the event.

   While there may be a desire in some jurisdictions for health care facilities, once full, to shut the doors, this action may lead to unrest during an event and significant ramifications following an event. The facilities themselves have no option, but to limit access during a pandemic, but should also be active in establishing alternatives for care that will create a tiered system that makes best use of resources, appropriately utilizes hospital beds and reassures the public that all efforts are being made to meet their needs.

i. Economic considerations must be secondary to immediate care needs of the community.

   Many health care facilities are either in deficit circumstances or at best are running with margins that are only a few weeks ahead of breaking even. Economic pressures will be enormous and governmental entities will need to provide economic support to enable hospitals to remain in operation.

B. Hospital Planning Considerations

As noted previously, each facility must develop its specifically tailored plan fitting the capabilities and resources of the organization. As a part of this, there are several key areas to consider:

1. Command and control processes
2. Surge capacity and bed management
3. Staffing
4. Education and training of staff
5. Disease surveillance
6. Infection control
7. Hospital risk communications
8. Patient triage
9. Clinical guidelines/protocols

10. Use of vaccines and antiviral drugs, if available
11. Mortuary issues
12. Security/facility access
13. Occupational health
14. Recovery of operations

Hospital Planning Assumptions

1. The number of people requiring outpatient medical care and hospitalization will overwhelm the local health care system perhaps as early as the second week of an influenza pandemic that has arrived locally.

2. Hospitals will be expected to maximize their medical surge capacity and capability; however, when requirements for care exceed hospital capabilities, alternate care either in the home or at alternative influenza care centers will be required to manage those who can be appropriately cared for outside the acute care hospital setting. Hospitals must be reserved for those influenza patients requiring critical care and those having other emergent health care needs, such as surgical and obstetric care.

3. The increased healthcare demands associated with pandemic influenza cannot be managed by healthcare facilities alone. An effective response must include hospitals, clinics, long-term care facilities, private practice physicians, home health care providers, pharmacies and the public health system.

4. Hospitals and other healthcare entities will experience staffing shortages throughout the pandemic period and into the subsequent recovery period. Under specific emergency conditions, volunteers, retired healthcare professionals, and trained unlicensed personnel may be used to provide patient care in a variety of healthcare settings.

5. Re-supply of depleted resources may not be readily available due to disruptions in the supply chain, so it may be necessary to identify re-usable supplies and the methods by which they can be sterilized.

6. Resources for mass fatality care at all levels, including health care facilities, the county morgues and mortuaries, may be inadequate to meet the demands for remains processing and storage posed by pandemic influenza.

7. To maximize healthcare resources and achieve the optimal benefit for the most people, traditional standards of care may need to be altered. Sufficient medical care may not be of the same quality as that delivered under non-emergency conditions, but may be the standard of care during an influenza pandemic.

Specific considerations

1. Command and Control Processes

Interpandemic and Alert Periods

a. Each health care facility should assemble an internal pandemic influenza planning group to develop a facility-wide pandemic influenza plan.
    1) The plan should specify the use of a command structure such as that of the Hospital Incident Command System (HICS), also known in an older version as HEICS. The website for this program is found in the web references in this Panhandle Health Pandemic Influenza Plan.
    2) The facility should specify the circumstances under which the plan will be activated.
    3) Define the responsibilities of key personnel related to the execution of the plan. Job action sheets for many positions can be found as part of the HICS program.
    4) The plan should incorporate the aspects noted below in the following specific considerations.
b. Define communication and coordination processes with other regional agencies and health care facilities such as through the Panhandle Multiagency Coordination Group discussed earlier in this Panhandle Health Plan.
c. Coordinate plan development and results with the other facilities through the regional coordinating (ASPR) group.

Pandemic Period

a. Activate the plan and provide notification through the communication and coordination processes defined in the plan.

2. Surge Capacity and Bed Management

Interpandemic and Alert Periods

a. Determine the potential added bed capacity that could be obtained using currently available staff and facilities.
b. Determine the potential surge capacity of beds if staffing were not rate limiting.
c. Determine the threshold at which elective admissions and surgeries would be cancelled to achieve added bed space.
d. Identify additional areas such as outpatient and other overflow spaces that may be converted to inpatient space.
e. Determine threshold at which surge beds would be opened.
f. Identify areas of the facility that could be vacated for use in cohorting influenza patients in response to a high census.

g. Develop plans for shifting patients between nursing units to free up bed space in critical care areas and/or to cohort pandemic influenza patients.
h. Develop a plan for expediting the discharge of patients who no longer require high levels of medical/surgical inpatient care.
i. Establish agreements with home health agencies for management of surgery and illness patients discharged early or to manage patients at home to diminish the need for admission.
j. Establish agreements with agencies that would be willing to specifically accept non-influenza patients in order to free bed space.
k. Establish arrangements to transport discharged patients home or to receiving facilities to expedite turnover of hospital beds.

Pandemic Period

a. In accordance with the defined triggers and as staffing allows, implement surge plan and bed management strategies.
b. Designate bed management "czar" to oversee the process.
c. Revise, as necessary, admission criteria to compensate for limited bed capacity.
d. Implement rapid discharge processes as defined in the plan.
e. Implement central bed status reporting to enable coordination across the Idaho Panhandle.

3. Staffing

Health care staffing will be a major concern during a pandemic. Health care workers will have an inherently greater risk of exposure to those with disease, and even if protected by vaccine or early antiviral agents, may suffer from fear or the need to be home to provide for family needs. Some estimates are that as many as 40 percent of health care workers may be absent due to a combination of personal or family illness, absence of care arrangements for children following closure of schools and the fear of contracting or bringing home to family a potentially fatal disease.

Alternatively, staff losses may have an early and severe effect on small practices where the loss of one or two people may force closure of the practice. The remaining staff may prove amenable to assisting at hospitals or other health care facilities.

Interpandemic and Alert Periods

a. Identify critical staff roles including healthcare workers, housekeepers, dietary, laundry, plant operations, security, chaplains, mental health staff and management, and develop plans to cover these critical roles.
b. Determine minimum staff levels required to maintain various levels of inpatient capabilities and to surge bed capacity.
c. Determine the minimum number and categories of personnel required to care for a group of patients with pandemic influenza.

d. Determine categories of personnel that might be cross-trained to perform additional needed duties, particularly in patient care areas, to compensate for inadequate or absent staff.
e. Develop templates of nursing notes and other patient care documentation specific to pandemic influenza to decrease the amount of staff time needed for documentation.
f. Develop work force preservation protocols to minimize absenteeism, which might include:
    1) Planning for a staff hotline with current information
    2) Providing sick-care services for children of hospital staff
    3) Create templates for rotation and rest of personnel over the duration of the pandemic.
g. Develop Memoranda of Understanding/Agreement with other facilities for potential sharing of staff.
h. Identify potential additional sources of personnel such as through the Medical Reserve Corps.
i. Develop processes for utilizing and managing volunteer staff:
    1) Designate the individual(s) responsible for assigning disaster responsibilities.
    2) If medical staff (privileged practitioners), designate the individual(s) responsible for granting disaster privileges.
    3) Designate process of verifying practitioner identity.
    4) Ensure there is a method to identify volunteer practitioners as such while working in the organization.
    5) Determine the method(s) to oversee the professional performance of volunteer practitioners.
    6) Develop process for primary source verification within the required timeframe when required by law.
    7) For community non-medical volunteers, also verify identity, provide volunteer identification, and ensure appropriate oversight while engaged in facility activities.
    8) Develop just-in-time training and orientation modules for temporary and volunteer staff.

Pandemic Period

a. Implement plan in accordance with above.
b. Designate person or persons appropriate for assessing and reporting day-to-day staffing capabilities and needs.

4. Education and Training of Staff

The process of education is an ongoing one and involves staff, patients, family members, facility visitors and other members of the community. Successful programs have the potential to improve recognition of disease, alleviate anxiety associated with uncertainty, decrease disease communication and improve compliance with instructions provided.

Interpandemic and Alert Periods

a. As part of its required ongoing educational programs and associated with training related to seasonal influenza (and

applicable to pandemic influenza), each hospital should provide staff education in infection control strategies for influenza, including respiratory hygiene/cough etiquette, hand hygiene, standard precautions, droplet precautions, and airborne precautions.

b. Following facility plan development, other topics to be taught and exercised should include those associated with the facility influenza plan including:
    1) Identifying, reporting and containing suspected cases of infection caused by novel influenza strains during the Interpandemic and Alert periods.
    2) Policies and procedures for the care of pandemic influenza patients.
    3) Pandemic staffing contingency plans, including how the facility will assist personnel with illness.
    4) Measures to protect family and other close contacts from secondary occupational exposure.
c. Document training as a part of personnel competency/HR files.
d. Identify and cross-train clinical personnel, including outpatient healthcare providers, who can provide support for essential patient-care areas (e.g., emergency department, ICU, medical units).
e. Make available specific reading materials on the facility plan and pandemic influenza to all staff members.
f. Ensure associated medical staff have access to local education on the facility's plan and general information on pandemic influenza.
g. Develop guidance for social workers, psychologists, psychiatrists and nurses for providing psychological support to patients and hospital personnel during influenza pandemic.
h. Develop appropriate psychological-support training for non-mental health professionals (e.g., primary care clinicians, leaders of community and faith-based organizations).
i. Ensure a plan is in place for rapidly training non-facility clinical and non-clinical staff brought in to provide care or assist those providing clinical care in a surge or staff shortfall situation.
j. Provide education to patients and family members on respiratory hygiene/cough etiquette, hand hygiene, standard precautions, droplet precautions, and airborne precautions as would be appropriate to minimize the infection with seasonal influenza as well as a novel influenza virus.

Pandemic Period

a. Implement updated training for personnel in accordance with the latest information on the influenza pandemic.
b. In coordination with the Public Information officer, begin education process for the community to manage expectations and to improve infection control.
c. Implement training for new and volunteer personnel.

d. Provide initial and ongoing training for medical staff on treatment priorities, allocating limited resources, and care standards as circumstances change.

5. Disease Surveillance

As noted earlier, rapid identification that a novel influenza virus has arrived in the community is critical to the implementation of multiple control measures and the minimization of community impact. The hospital emergency department will be one of the sentinel locations in which early identification may occur, so the process for surveillance will be of great importance. Surveillance includes surveillance for influenza viruses (virologic surveillance) and surveillance for influenza-associated illnesses and deaths (disease surveillance). There is currently no syndromic surveillance at any of the health care facilities of North Idaho, so more traditional measures will be required to enable the earliest identification possible.

Interpandemic and Alert Periods

a. Hospitals with emergency departments and outpatient treatment clinics should develop and utilize monitoring criteria to identify patients presenting with influenza-like illness.
b. Patients admitted with laboratory-confirmed influenza should also be identified as part of monitoring.
c. Results of this monitoring should be reported to Panhandle Health District for district-wide aggregation and results reporting of aggregated to all participating facilities.
d. Monitor employee absenteeism for increases that might indicate early cases of pandemic influenza and as appropriate share this information with Panhandle Health Epidemiology.

Pandemic Period

a. Provide active ongoing monitoring and reporting to Panhandle Health to enable epidemic analysis.

6. Infection Control

Since the pandemic influenza virus has yet to appear, disease specific infection control measures cannot be developed, but based upon the assumption that it would behave as an airborne virus similarly to other influenza viruses, airborne precautions along with droplet and contact precautions should be utilized during an influenza pandemic. As disease specific information becomes available additional or altered precautions will be identified and implemented.

Interpandemic and Alert Periods

a. The hospital should perform an assessment to evaluate potential vulnerabilities related to all possible modes of transmission including airborne.

b. Considering these vulnerabilities, develop a specific infection control strategy for pandemic influenza (which can also be generalized to consider all highly infectious airborne diseases) including:
    1) Identification strategies
    2) Containment stategies
        a) Isolation
        b) Cohorting
    3) Respiratory hygiene
    4) Staff issues
        a) Personal protective equipment
        b) Training
        c) Screening for infected staff
    5) Environment of care issues
        a) Equipment cleaning
        b) Waste disposal
c. Determine general levels of Personal Protective Equipment (PPE) to be utilized and, based upon hospital plans designate locations for treatment and cohorting of influenza patients, determine additional levels of PPE required.
d. Have a respirator program in place, including appropriate fit-testing.
e. Pre-designate which positions and, if possible, which employees may be required to wear respiratory protection.
f. Ensure that potential respirator-wearing employees have been medically cleared, have a suitable respirator model through individual fit-testing, and have been trained in respirator use.
g. Have adequate supplies of respirators and other PPE on-site.
h. Have arrangements in place to acquire additional equipment on short notice.
i. Educate health care workers on the importance of containing respiratory secretions to prevent the transmission of influenza.

Pandemic Period

<u>Persons Entering the Facility</u>

a. Implement measures to detect persons entering the facility who may have pandemic influenza:
b. Post visual alerts at the entrances to all hospital and outpatient facilities in appropriate languages with instructions to implement the following measures:
    1) Immediately report symptoms of respiratory infection to the health care provider.
    2) Wash hands with soap and water or alcohol-based hand gel after contact with respiratory secretions.
c. In common waiting areas, maintain spatial separation (ideally at least 3 feet) between people and particularly symptomatic persons and others.
d. Triage patients calling for medical appointments for influenza symptoms to differentiate patients who need emergency care

from those who can be referred to a medical office or other non-urgent care facility.

e. Limit the number of entrances to the healthcare facility, based on ability to provide appropriate screening.
f. Provide security at entrances.
g. Consider designating a separate entrance and waiting area for patients with influenza-like symptoms.
h. Establish a "triage officer" to manage flow, including deferring or redirecting patients who do not require emergency care, after performing a medical screening examination.
i. Implement a system to screen all healthcare personnel for influenza-like symptoms before coming on duty.

Hygiene/Contact Precautions

a. Implement measures to limit dissemination of influenza virus from respiratory secretions including:
    1) Covering mouth/nose with a tissue when coughing.
    2) Disposing of used tissue in contained receptacles.
    3) Applying a surgical mask on the coughing person, if it can be tolerated.
    4) Hand hygiene after contact with respiratory secretions.
    5) Ensure spatial separation, ideally >3 feet, of persons with respiratory infections in common waiting areas when possible.
b. Implement droplet precautions:
    1) Patients with known or suspected pandemic influenza should be placed on droplet precautions for a minimum of 5 days, and up to 14 days, from the onset of symptoms. Immunocompromised patients may shed virus for longer periods and therefore should be placed on droplet precautions for the duration of their illness.
    2) Healthcare personnel should wear appropriate PPE.
c. If the pandemic virus is associated with diarrhea, contact precautions (i.e., gowns and gloves for all patient contact) are to be added.
d. Educate staff, and, as appropriate, patients and visitors on these measures and their importance in preventing spread of influenza.

Personal Protective Equipment

Health care personnel should be instructed in and, as appropriate, be required to wear personal protective equipment (PPE)

a. N95 Respirators
    1) N95 respirator masks should be available and placed into use as soon as it has been identified that a pandemic influenza virus has reached the region since determination of which patients or staff might be infected is not possible in the earliest stages of the disease.
    2) An N95 respirator should be worn when entering a patient's room.

3) Ideally, a mask should be worn once and then discarded. When supplies of respirators become scarce or N95 respirators are no longer required updated guidelines may be required.
4) If pandemic influenza patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one respirator for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between patients and hand hygiene performed.
5) Change respirators when they become moist.
6) Do not leave respirators dangling around the neck.
7) Upon touching or discarding a used respirator, perform hand hygiene.
8) During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning), health care personnel should wear an N95 respirator or other appropriate particulate respirator, as well as gloves, gown and face/eye protection.
9) While they may be necessary, nebulizer treatments and other droplet generating procedures should be avoided, and when performed preferably done in a negative pressure room.

b. Gloves
1) Gloves must be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves may be of latex, vinyl, nitrile, or other synthetic materials, but, if possible, latex-free gloves should be available for health care workers who have a latex allergy.
2) Remove and dispose of gloves after use on a patient; do not wash gloves for reuse.
3) Perform hand hygiene after glove removal.
4) If gloves become in short supply, priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive patient or environmental contact with blood or body fluids, including during suctioning.
5) Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient's respiratory secretions such as to handle used facial tissues. Hand hygiene should be strongly reinforced in these situations.

c. Gowns
1) While most patient interactions do not necessitate the use of gowns, procedures such as intubation and activities that involve holding the patient close (e.g., in

pediatric settings) are examples of when a gown may be needed when caring for pandemic influenza patients. Wear an isolation gown, if soiling of personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated.

2) Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.
3) If gowns are in short supply, priorities for their use may need to be established and the cirmstances for use strictly enforced. Other coverings may be found that might be used, but paper "modesty" gowns and aprons will not likely prevent the penetration of fluid containing the virus and should be avoided. There is no data upon which to base a recommendation for reusing an isolation gown on the same patient, so this practice should be avoided.

d. Goggles or face shield
    1) In general, wearing goggles or a face shield for routine contact with patients with pandemic influenza is not necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for standard precautions.

<u>Hospitalization of pandemic influenza patients</u>

a. Patient placement
    1) Ideally, patients with suspected or laboratory-confirmed illness caused by a novel pandemic influenza virus must be placed into negative-pressure isolation rooms. This may be possible only for the first few presumed or identified cases, since the number of negative pressure rooms is severely limited in northern Idaho.
    2) Patients in the early stages of disease must be placed on airborne precautions.
    3) Cohort patients, as necessary, to facilitate care and to minimize exposure to others.
    4) Negative pressure rooms or procedure rooms must be used to decrease the risk of transmission within the hospital during aerosol-generating procedures (i.e., bronchoscopy, endotracheal intubation).
    5) Contact precautions must be used for patients with symptoms of diarrhea.
    6) Immunocompromised patients may shed virus for longer periods and must be placed on airborne precautions for the duration of their illness.

<u>Cohorting</u>

The collecting of patients having pandemic influenza into a defined and controlled area will help to prevent cross-contamination of others that have been hospitalized for other causes. In some cases, this might also enable environmental control related to air

handling and filtering, as well as infectious waste management and other aspects of providing comprehensive care for this group of patients. Only patients with confirmed diagnoses of pandemic influenza would be assigned to this area.

a. Implement cohorting as early as possible to accommodate an anticipated surge and to minimize spread. This also will allow some time for facility adjustments for a growing number of patients.
b. Designate units or areas of the facility for cohorting patients with pandemic influenza and preferably negative pressure isolation rooms.
c. Consult with facility engineers when determining areas to cohort patients to address ventilation systems that are not shared with other areas or rooms.
d. Ensure that personnel assigned to the cohorted patient care units do not "float" or are otherwise assigned to other patient care areas.
e. Limit the number of personnel entering the cohorted areas to those necessary for patient care and support.
f. Ensure that healthcare personnel adhere to infection control practices to prevent hospital acquired transmission.

Patient transport

a. Movement of patients with pandemic influenza outside the isolation areas should be limited as much as possible and only for medically essential reasons.
b. To the extent possible, portable equipment, such as x-ray machines, should be used in the isolation areas and thoroughly cleaned after each use.
c. If transportation is necessary, patients should wear a surgical or procedure mask, if tolerated. If a patient cannot tolerate a surgical mask, apply the most practical measure to contain respiratory secretions such as placing a sheet or towel loosely over the nose/mouth or head, during transport.

Visitors

While visitors are a source of comfort, they are also both a source of potential infection and would themselves be at risk of infection in the facility. As such, policies regarding visitors should be carefully considered and strictly adhered to.

a. Consider only allowing visitors who specifically provide for the patient emotional well-being and are able to assist in provision of care or visitors that are operationally critical for the facility (such as suppliers).
b. Post instructions on respiratory and cough etiquette and hand hygiene methods at entries and in patient rooms and make necessary supplies and disposal cans available.
c. All visitors must be screened for signs and symptoms of influenza before entry into the facility and exclude persons who are symptomatic.

d. Masks should be provided and worn by all visitors while in patient's rooms or while in immediate contact with others.
e. Educate visitors to pandemic influenza patients on the importance of wearing surgical or procedure masks, and using good hygiene including respiratory/cough etiquette.

Prevention of hospital-acquired pandemic influenza

Once patients with pandemic influenza begin to be admitted to the hospital, the risk for hospital-acquired infection (HAI) with influenza becomes significant. Many patients who continue to undergo hospital treatment for other indications will be at risk of having clinical courses complicated HAI therefore internal surveillance will need to be increased and strict measures taken to prevent transmission to other patients and staff.

a. Cohort influenza patients on designated units.
b. Limit movement of staff between units to the minimum necessary.
c. Disposal of solid waste: Standard precautions for contact with blood and bloody fluids (i.e., gloves) are required for biohazardous waste; there are no special precautions that are recommended for disposal of respiratory secretions.
d. Linen and laundry: Healthcare facilities should use standard precautions.
e. Dishes and eating utensils: Standard precautions are recommended for handling dishes and eating utensils used by a patient with known or possible pandemic influenza. Infection control policies and procedures must address proper cleaning and use; disposable products are not required.
f. Patent care equipment: Follow standard practices for handling and reprocessing used patient care equipment including medical devices.
    1) Hospital personnel must wear gloves when handling and transporting contaminated patient care equipment.
    2) Hospital personnel must decontaminate patient care equipment with an EPA-approved hospital disinfectant before removing it from the patient's room; clean, disinfect or sterilize re-usable patient care equipment as appropriate.
    3) Hospital personnel should decontaminate external surfaces of portable equipment used to perform x-rays and other procedures in the patient's room with EPA-approved hospital disinfectant and upon removal from the patient's room.
g. Apply these precautions to all patient care, not just in the pandemic influenza cohort areas, because **it is critical to remember that persons may have and be contagious with influenza for 24 hours prior to the development of symptoms, so an asymptomatic individual admitted for**

another cause could ultimately also be a source contact for influenza.

Post-mortem care

a. Hospitals will follow standard facility practices for the care of the deceased including standard precautions for the contact with blood and body fluids (i.e., gloves).
b. If autopsy or procedures are performed on a deceased person with suspected or confirmed influenza and the procedures involve generating higher concentration of aerosols (e.g., cutting through bone), a powered air purifying respirator(PAPR) with N, P, or R-100 cartridge must be worn.

7. Hospital Risk Communications

Hospital communications to its patients, staff and the community will be critical in the event of an influenza pandemic. Effective communication guides the public, the news media, health care providers, and other groups in responding appropriately to outbreak situations and adhering to public health measures. Information will come from a variety of sources and should be coordinated with other facilities to minimize confusion and inconsistency, since the public will be receiving information from multiple sources. During the late phases of the Alert Period and throughout the Pandemic Period, the Public Information position of Panhandle Health District will be very active and information will be shared with all partner agencies.

Interpandemic and Alert Periods

External Communication

a. Designate a single point of contact with whom Panhandle Health District can communicate on a regular basis.
b. Participate as part of ongoing inter-agency public information coordination.
c. Prepare or determine readily available sources for messages and information for use on websites, in recorded messages, in postings, etc.

Internal Communication

a. Prepare or have access to sources of messages and information for staff, patients and visitors.
b. Evaluate internal communication mechanisms by disseminating information relative to seasonal influenza prevention and pandemic influenza preparedness and assessing effectiveness.

Pandemic Period

a. Maintain a single contact to engage with the Panhandle Health District Public Information Officer.
b. Utilize established mechanisms for external communication and media request coordination.

c. Keep partner agencies informed of status changes including closure to patient admissions, the need for changes in protocols, supply shortages, etc.

8. Patient Triage

Triage will be critically important to manage patient flow and to ensure that people are treated in the appropriate way and in the appropriate setting. Triage will be performed by protocol to maintain consistency, but triage protocols may change during the course of the pandemic to meet changing demands and resources. Example triage protocols are included as tools associated with this plan.

The goals of triage will be to:

- Identify persons who might have pandemic influenza.
- Separate potentially infected persons from others to reduce the risk of disease transmission.
- Identify the type of care they require (i.e., homecare or hospitalization)

Interpandemic and Alert Periods

a. Develop a triage and admission plan.
b. Plan a specific location for triage of possible pandemic influenza patients, if possible, external to the facility.
c. Include use of signage to direct patients with influenza symptoms to the triage area.
d. Plan for physical separation for those with possible influenza from patients seeking care for other reasons.
e. Develop a system for phone triage to identify patients who need emergency care and those who can be referred to a medical office or other non-urgent facility.
f. Ensure a method for tracking the admission and discharge of patients with pandemic influenza has been developed.

Pandemic Period

a. Designate a specific location for triage of patients with possible pandemic influenza.
b. Implement telephone triage process.
c. Assign a triage coordinator to manage patient flow including referral patients who do not require emergency care.
d. Assign separate waiting areas for persons with respiratory symptoms.
e. Periodically review and update procedures for the clinical evaluation of patients in the emergency department and in outpatient medical offices to facilitate efficient and appropriate disposition of patients.
f. Periodically reassess admission procedures and streamline them as needed to limit the number of patient encounters in the hospital.

9. Clinical Guideline/Protocols

The management of influenza is based primarily on sound clinical assessment and management of individual patients. This can be facilitated by protocols that assist in the identification and appropriate treatment of patients. Initial possible protocols have been included in Section XII of this plan, but as more information becomes available, the pandemic progresses and resources become limited, protocols may require modification to optimize the use of the remaining resources. These modifications must not only consider facility resources, but must be scientifically based, ethical and supportable. Protocols should also be coordinated at the regional level to provide consistency.

Interpandemic and Alert Periods

a. Hospital pandemic influenza plans should incorporate regionally coordinated management triage and management guidelines.
b. Plans should include mechanisms to ensure all clinicians will receive protocols (one such mechanism is broadcast via the Health Alert Network).

Pandemic Period

a. Implement plans including protocols previously developed.
b. Participate in development of updated protocols and circumstances change.
c. Communicate modified plans to all clinicians and operational areas.

10. Use of Vaccines and Antiviral Drugs

Early in the course of a pandemic there will likely not be an effective vaccine and the supply of anti-viral medication will be limited. Health care workers will be among the first to be immunized if a vaccine is available and will be among the earliest to have the benefit of antivirals, but not all health care workers will have equal access in the earliest period. Current guidelines designate initial antiviral medications for use in treatment of those with disease with prophylaxis to occur if medications are then available. Details on the use of vaccines and anti-viral therapy can be found in Section XVI of this plan.

Interpandemic and Alert Periods

a. Monitor both Health and Human Services updates available at http://www.pandemicflu.gov and information provided by Panhandle Health on a periodic basis.
b. Provide estimates of the number of staff that would require immunization or prophylactic antiviral medication, if available.
c. Ensure a plan is in place for rapid immunization of hospital staff should vaccine become available.

Pandemic Period

a. Follow guidelines issued for use of antiviral medications.
b. Implement immunization plan if vaccine becomes available.

11. Supplies

During an influenza pandemic, supply chains are likely to be severely disrupted. Additional durable supplies will be difficult to obtain and consumables, that will be rapidly depleted, may not be readily replaceable. Planning will need to consider the limitations created by the decreased availability of medical supplies.

Interpandemic and Alert Periods

a. Identify supplies critical to the care of pandemic influenza patients.
b. Determine usage levels and stockpile enough consumable resources for the duration of a pandemic wave (8-12 weeks).
c. Develop a strategy for acquiring additional equipment, (e.g., ventilators).
d. Determine which supplies might be reused under critical shortfall circumstances and the means by which sterilization might be performed.
e. Determine usage levels and stockpile food and water to care for patients and staff for the duration of a pandemic wave.
f. Develop a strategy for acquiring additional food and water supplies.
g. Exercise systems for procuring and storing additional supplies and stockpile rotation issues.

Pandemic Period

a. Monitor critical supplies inventories and activate appropriate MOUs with vendors.
b. Identify shortfalls of supplies to the Panhandle Multi-agency Coordination Group.
c. Monitor critical supplies of food and water and activate appropriate MOUs with vendors.

12. Mortuary Issues

Interpandemic and Alert Periods

a. Assess the hospital capacity for storage of remains of deceased persons.
b. Address alternate storage facilities and development of a temporary morgue.
c. Plans should address the need to manage contaminated remains.
d. Obtain or ensure rapid availability of necessary supplies such as body bags to handle the increased number of deceased persons.

Pandemic Period

a. Activate the mortuary plan in coordination with the medical examiner.

13. Security and Facility Access

Additional security will be required to ensure controlled access to the facility. There will be an increased demand for services and long wait times. Triage and treatment decisions may not be accepted without dissent and it may be necessary to lock down the health care facility limiting entrance to staff and patients meeting admission criteria.

Interpandemic and Alert Periods

a. Develop a security plan determining the process to enhance hospital security and limit access to the facility if pandemic influenza spreads through the community.
b. Define essential and non-essential visitors to the facility and develop protocols for how each will enter.
c. Develop controls to ensure the hospital is able to secure all entrances.
d. Plan for additional security during a critical pandemic wave.

Pandemic Period

a. Implement the security plan as developed.

14. Occupational Health and Employee Support

Health care personnel will be at risk of acquiring pandemic influenza through both community and health care related exposures. Once pandemic influenza has reached North Idaho, healthcare facilities must implement systems to monitor for illness in the facility workforce and manage those who are symptomatic or ill.

Interpandemic and Alert Periods

a. Implement a system to educate personnel about occupational health issues related to pandemic influenza.
b. Promote annual influenza vaccination among hospital employees to both improve acceptance of immunization and to eliminate the confounding variable of seasonal flu as a likely diagnosis in those manifesting influenza-like illness.
c. Utilize a system for documenting influenza vaccination of health care personnel.
d. Establish a plan for rapidly vaccinating or providing antiviral prophylaxis or treatment to health care personnel as recommended by Idaho Department of Health and described in

Section XVI Immunization and Antiviral Therapy of this PHD Pandemic Influenza Plan.

e. Develop a means of screening staff for influenza symptoms before they begin duty on a daily basis.
f. Ensure employees are trained on home preparation.
g. Develop planning for potential child and eldercare in a effort to enable workers to remain serving.

Pandemic Period

a. Implement screening of personnel for influenza-like symptoms before they come on duty. Symptomatic personnel should be sent home until they are physically ready to return to duty.
b. Medical personnel at increased high risk for complications of pandemic influenza (e.g., pregnant women, immunocompromised persons) should be informed about their medical risk and offered an alternate work assignment, away from influenza-patient care, or considered for administrative leave during the pandemic.
c. Provide access to mental health and faith-based resources for counseling of health care personnel.
d. Provide assistance to staff that have child-care or eldercare responsibilities so the staff may remain available to work.
e. Implement strategy for supporting health care workers' needs for rest and recuperation.
f. Implement strategy for housing and feeding health care personnel who might be on-site for prolonged periods.
g. Personnel who have recovered from pandemic influenza should develop protective antibody against future infection with the same virus, and therefore may be ideally suited to care for others with active pandemic influenza and its complications.

15. Administration

As noted previously, medical and other records should be streamlined for efficiency. This is possible, in part, due to the likelihood in a pandemic that a large number of patients will have common symptoms making templated documentation practical. In addition, care will be primarily targeted at acute, influenza-related needs, so some of the normal discharge planning and management of other problems will need to be deferred or managed as minimally necessary at the time.

In addition, costs will be significant and this information needs to be captured as a separate accounting item to enable potential collection of reimbursement by FEMA or other agencies. An elaborate cost-accounting system should be unnecessary since the fundamental items of care and supplies used are those that would be used in the care of any patient with a complicated respiratory infectious disease. Costs should be separate from routine care, but can remain within the same accounting systems.

Interpandemic and Alert Periods

a. Develop document templates for provision of care to pandemic influenza patients.
b. Develop a separate cost center or more as are needed to provide cost accounting in the event of a pandemic.

Pandemic Period

a. Compile documentation of costs associated with care of patients having pandemic influenza.
b. Ensure coordination with Panhandle Multi-Agency Coordination Group to receive any specific accounting, medical administrative or mortality reporting requirements that have been imposed by the Bureau of Homeland Security, Centers for Disease Control or other agencies.

16. Recovery of Operations

Pandemic influenza will occur in waves and while cases may not completely disappear between waves, there may be enough of a decrease to allow for a period of recovery and preparation for another wave of cases. Planning must address how this opportunity for temporary recovery will be effectively used.

Interpandemic and Alert Periods

a. Develop a process for documenting resource utilization.
b. Develop sources that can provide rapid supply of medical materials, food and water.

Pandemic Period

a. Determine best practices and capture lessons learned that will enable preparation for the next wave.

Between Waves

a. Adjust plans based upon lessons learned in preparation for the next wave.
b. Replenish supplies based upon the experience gained.

C. Transitional Issues

During a pandemic, there will be several points at which transitions will occur in health services provided to the community. While there will be limited transitions as greater WHO stages are reached, the primary transitions will be:

- When the initial patient with the novel influenza virus is admitted in a local facility.
- When the number of cases exceeds usual isolation capability.
- When it is determined that health services will need to be modified to cease elective cases and non-urgent care.
- When facilities reach capacity and admissions must be restricted.

- When resources such as supplies and/or staff become limited.
- When, as the wave of illness is abating, it becomes possible to loosen the admission criteria.

In addition, more poorly defined transitions during these latter stages as supply resources are exhausted.

1. Admission of the First Novel Influenza Patient

Once Phase 4 of the Interpandemic Period has been reached, surveillance will be critical and any patient manifesting influenza-like symptoms must be treated as potentially having a novel influenza virus. These patients must be treated as would anyone having a highly virulent respiratory disease. Negative isolation rooms should be employed and all appropriate infection control measures implemented.

In the absence of additional guidance from the Centers for Disease Control or the World Health Organization, medical care will be governed by the same principles as would be in effect for any individual with a virulent and highly contagious respiratory disease.

2. Cases Exceed Usual Isolation Capability

The number of negative pressure rooms in northern Idaho is limited, and once these have been saturated it will become necessary to provide care within the setting of the general medical or intensive care unit beds. Hospitals routinely have patients in the general medical setting that require contact precautions whether for bacterial or viral causes. In the setting of a pandemic influenza this will be complicated by the great potential of droplet spread and by the number of patients that will simultaneously need care.

When the number of patients exceeds standard isolation room capability, all patients, medical condition permitting, should be cohorted to a single inpatient unit or intensive care unit area, as appropriate. This has the advantages of:

- Decreasing the risk of spread by isolating care to a given area.
- Enabling focused education and preparation of staff.
- Using streamlined documentation and procedures due to the single primary diagnosis of all patients in the area.
- Creating a subset of staff on which vaccine or prophylactic/treatment antiviral agents can be focused.

3. When Cases Reach a Level Necessitating a Change in Operations

As the number of cases increases, it will become necessary to modify the usual operations of health care facilities including ceasing elective surgery and limiting non-urgent care. Increasing cases in the community will result in greater absenteeism of staff due to personal illness or the need to

provide their own family care. Also, public concerns will likely be focused away from elective procedures thereby decreased demand for these services. More and more units will need to be utilized for influenza care and ventilators normally used in surgical procedures may need to be used for influenza patient support.

The trigger for this change must be defined by the facility, but it should be that point at which the need for influenza beds exceeds the beds available while continuing non-urgent and non-emergent care.

It should be expected that the volume of true emergency care will continue nearly unchanged. Traumatic injuries, births, surgical emergencies and medical illnesses will continue to occur and require treatment. This will also limit the ability to focus all resources on management of pandemic influenza patients. Each facility must include in its plan the maximum volume of influenza care and the amount of ongoing emergency care it will be able to provide. In doing this, the facility will define the triggers

One potential alternative may be for regional facility coordination of care such that certain facilities would focus on influenza patients while others became central areas for non-influenza patients. This would potentially decrease the risk of cross-infection with influenza of those admitted for non-influenza conditions. Such an effort would require close coordination and an income sharing agreement between facilities.

4. When Facilities Reach Capacity

In most models, a severe pandemic will result in saturation of inpatient bed capacity by the third week of the outbreak despite changes in operations as noted above. When this occurs, it will no longer be possible to provide inpatient services to all who might need them. While the bulk of care for influenza patients will occur in the home and be provided by family members, unless there is some alternative mechanism for providing care to those who are too sick to remain at home caring for themselves or whose family members can no longer provide care, excess deaths will occur that might otherwise be prevented.

Alternatives in this situation include providing home care and developing and alternative influenza care center that would provide intermediate level care, leaving hospital beds for only the most ill. Protocols would guide care in the care centers and specific admission criteria would govern referrals to the hospital. Protocols and guidelines will also guide internal capacity decisions, such as who would be eligible for intensive care services. Some potential guidelines are provided in the section of this plan concerning patient management protocols.

5. When Supply and/or Personnel Resources Become Limiting

Rather than being a pure transition point, this represents a variation of that seen in number four above. This transition may never occur, but it is likely unless supply chains remain intact or there are large local stockpiles of

materials. While the Strategic National Stockpile might provide additional resources, it is unlikely to be available to northern Idaho in an event that is having large national impact.

If this circumstance occurs, it will limit the types of care that can be provided regardless of the site in which that care might be given. Even more critical will be decisions on who should get intensive care beds. Decisions will also be required on how many resources should be expended on a single individual if the use of those same resources might potentially save several others. Some of these decisions will be protocol driven or will utilize the Sequential Organ Failure Assessment (SOFA) Score, as shown in the aids provided in this plan. Ultimately, an active facility ethics committee may be required to play a key role in this process.

In addition, risk/benefit decisions will need to be made concerning the reuse of disposable items intended for single use. While there are commercial entities that prepare medical materials for reuse, this would need to be done at the local level using very strict infection control processes.

6. Abating Illness Enables Changing of Admission Criteria

Although providing some relief in the difficult circumstances experienced in the other phases, this transition has its own challenges. Since pandemic illnesses occur in waves and the cycle times are difficult to predict, this transition can be among the most difficult. Relaxed criteria one day might need to again be made more rigorous the next. This also will need to be carefully approached from a community awareness standpoint.

XII. NON-HOSPITAL CARE

In an influenza pandemic, the large majority of care will occur in settings other than acute care hospitals. Acute care hospitals will not have the capacity to provide inpatient care other than for those requiring the highest level of care and in even these situations there may be more requiring care than there exists the capacity to provide it. Care will necessarily also occur in a number of other venues including:

A. Surgical Care Centers, Skilled Nursing Facilities and Residential Care Facilities
B. Urgent Care Clinics and Group Practices
C. Individual Practices
D. Professional Home Care
E. Family and Personal Home Care

A. Surgical Care Centers, Skilled Nursing Facilities and Residential Care Facilities

These all have in common the fact that they either are already “bedded” facilities or have the capability to house inpatients. In addition, they also have associated staff, such as nurses, that are already trained for performing vital signs and managing patients beyond those seeking general outpatient appointments. Surgical care centers and some skilled nursing facilities also have important

assets such as airway management equipment. All of these settings would have some familiarity with the use of supplemental oxygen and potentially of intravenous therapy as well.

1. Surgical Care Centers

Interpandemic and Alert Periods

a. Create a planning team and develop a written plan for continued operation of the facility during pandemic influenza and altering from a purely outpatient facility to a temporary inpatient facility.
b. Establish a decision-making and coordinating structure that can be tested during the Interpandemic period and will be activated during a pandemic.
c. Determine the number of patients the facility would be able to manage as inpatients and the number, if any, that could be maintained on ventilator support.
d. Determine if the facility is to accept direct admissions such as from EMS or an Alternative Influenza Care Center or if admissions will only occur in referral from another acute care facility.
e. Establish the type of patients that will be accepted, such as whether the facility will accept infectious disease patients or will only accept medical and surgical patients needing recovery, but believed to be infected with Pandemic influenza.
f. Establish memoranda of understanding with Panhandle Health District and/or the county inpatient facility to delineate the process and triggers by which transition to an inpatient facility would occur.
g. Based upon this change in care pattern from outpatient to inpatient care, perform an assessment to evaluate potential infection control vulnerabilities related to all possible modes of transmission including airborne. (**Note: Even if the facility is only accepting presumed non-influenza patients, it is possible that individuals could still be in a presymptomatic period, and precautions must be taken until it is clear they are not longer at risk.)**
h. Considering these vulnerabilities, develop a specific infection control strategy for pandemic influenza (which can also be generalized to consider all highly infectious airborne diseases) including:
    1) Identification strategies
    2) Containment stategies
        a) Isolation
        b) Cohorting
    3) Respiratory hygiene
    4) Staff issues
        a) Personal protective equipment
        b) Training
        c) Screening for infected staff

5) Environment of care issues
    a) Equipment cleaning
    b) Waste disposal

b. Determine general levels of Personal Protective Equipment (PPE) to be utilized and, based upon organization plans designate locations for treatment and cohorting of influenza patients, determine additional levels of PPE required.
c. Have a respirator program in place, including appropriate fit-testing.
d. Pre-designate which positions and, if possible, which employees may be required to wear respiratory protection.
e. Ensure that potential respirator-wearing employees have been medically cleared, have a suitable respirator model through individual fit-testing, and have been trained in respirator use.
f. Have adequate supplies of respirators and other PPE on-site.
g. Have arrangements in place to acquire additional equipment on short notice.
h. Educate health care workers on the importance of containing respiratory secretions to prevent the transmission of influenza.
i. In planning, consider other aspects of acute care operations as detailed in the Hospital Care Section of this plan.
j. Exercise facility communication and coordination with Panhandle Health and other health care partners.

Pandemic Period

Most of the same considerations that apply for inpatient bedded facilities will also apply to these temporary acute care hospitals. Facilities should refer to the Hospital care section of this plan. In addition, because the facility is not usually an inpatient facility and does not have an emergency department component through which patients would be evaluated and admitted, other considerations include:

a. Post signage in appropriate languages directing patients seeking direct care to the nearest clinical facility for evaluation.
b. Based upon determinations in "c" above as to admissions policies, communicate initial admission criteria to either EMS or to referring facilities.
c. On an established schedule, communicate bed and operational status to the Panhandle Multi-Agency Coordination Group (PMACG).
d. Communicate identified shortfalls to the PMACG.
e. Coordinate changes in admission and treatment criteria and protocols with other health care facilities via the PMACG.

2. Skilled Nursing Facilities

Skilled nursing facilities (SNF) will continue to have their normal patient population, but will also need to plan to add beds to provide care of medical or surgical patients needing supplemental oxygen and/or intravenous fluids. **In addition, since they are already bedded hospital**

facilities, many of the same concerns regarding infection control, staffing, and other types of resource issues that are experienced by acute care hospitals will also apply to SNF.

Interpandemic and Alert Periods

a. Create a planning team and develop a written plan for continued operation of the facility during pandemic influenza and expansion to provide additional staffed beds.
b. Examine the hospital care section of this plan to assess for relevant considerations.
c. Establish a decision-making and coordinating structure that can be tested during the Interpandemic period and will be activated during a pandemic.
d. Determine the number of additional patients the facility would be able to manage either temporarily or on an ongoing fashion.
e. Determine if the facility is to accept direct admissions such as from EMS or an Alternative Influenza Care Center or if admissions will only occur in referral from another acute care facility.
f. Establish the type of patients that will be accepted, such as whether the facility will accept infectious disease patients or will only accept medical and surgical patients needing recovery, but not believed to be infected with Pandemic influenza.
g. Determine how to conduct internal surveillance for pandemic influenza in staff personnel and in the clients served.
h. Develop policies and procedures for managing pandemic influenza in patients and staff.
i. Educate and train healthcare personnel on pandemic influenza, appropriate levels of infection control precautions, wearing appropriate PPE, and the facility's response plan.
j. Develop a plan for procuring the supplies such as personal protective equipment and other supplies needed to maintain and expand operations.
k. Establish memoranda of understanding with Panhandle Health District and/or the county inpatient facility to delineate the process and triggers by which acceptance of patients would occur.
l. Participate in ongoing planning with the regional planning group.
m. Exercise facility communication and coordination with Panhandle Health and other health care partners.

Pandemic Period

a. Implement expansion plans.
b. Notify Panhandle Health when able to accept patients.
c. Participate in Panhandle Multi-Agency Coordination Group.
d. Coordinate with PMACG on changes in triage, admission and discharge protocols.

3. Residential Care Facilities

While capabilities of residential care facilities may not be as robust as those of surgical hospitals and skilled nursing facilities, the availability of trained nursing staff, also having training in supplemental oxygen and intravenous therapy, enables these facilities to also potentially provide a source of care particularly for med/surg patients who no longer need an acute care setting, but are not yet ready for home discharge. Since the normal residents of residential care facilities would be at high risk should they become infected with the influenza virus, it is unlikely that these facilities would accept patients known or suspected to be infectious, but many of the infectious disease precautions would remain the same as noted for other care facilities.

Interpandemic and Alert Periods

a. Create a planning team and develop a written plan for continued operation of the facility during pandemic influenza and expansion of staffed bed capacity.
b. Examine the hospital care section of this plan to assess for relevant considerations.
c. Establish a decision-making and coordinating structure that can be tested during the Interpandemic period and will be activated during a pandemic.
d. Determine the number of additional patients the facility would be able to manage either temporarily or on an ongoing fashion.
e. Establish the type of patients that will be accepted, such as whether the facility will accept infectious disease patients or will only accept medical and surgical patients needing recovery, but not believed to be infected with Pandemic influenza.
f. Determine how to conduct internal surveillance for pandemic influenza in staff personnel and in the clients served.
g. Develop policies and procedures for managing pandemic influenza in patients and staff.
h. Educate and train healthcare personnel on pandemic influenza, appropriate levels of infection control precautions, wearing appropriate PPE, and the facility's response plan.
i. Develop a plan for procuring the supplies such as personal protective equipment and other supplies needed to maintain and expand operations.
j. Establish memoranda of understanding with Panhandle Health District and/or the county inpatient facility to delineate the process and triggers by which acceptance of patients would occur.
k. Participate in ongoing planning with Panhandle Health District for potential expansion.
l. Exercise facility communication and coordination with Panhandle Health and other health care partners.

Pandemic Period

a. Activate plans for bed expansion as requested by the Panhandle Multi-Agency Coordination Group.
b. Notify Panhandle Health when able to accept patients.
c. Coordinate with PMACG on changes in triage, admission and discharge protocols

B. Urgent Care Centers and Group Practices

Urgent care centers, group practices and individual practices will be among the first to potentially identify the rise in illness associated with an influenza pandemic. Surveillance and ongoing communication will be important. In addition, these providers will be the primary source of professional care provided to outpatients during a pandemic and will be key to the screening process for those needing admission to hospitals.

Interpandemic and Alert Periods

a. Create a planning team and develop a written plan for continued operation and increased demands in the face of decreased staffing.
b. Examine the hospital care section of this plan to assess for relevant considerations.
c. Establish a decision-making and coordinating structure that can be tested during the Interpandemic period and will be activated during a pandemic.
d. Determine how to conduct internal surveillance for pandemic influenza in staff personnel and in the clients served.
e. Develop policies and procedures for managing pandemic influenza in staff.
f. Educate and train personnel on pandemic influenza, appropriate levels of infection control precautions, wearing appropriate PPE, and the organizations's response plan.
g. Develop a plan for procuring the supplies such as personal protective equipment and other supplies needed to maintain and expand operations.
h. Determine how the facility will communicate with patients and assist in educating the public regarding prevention and control measures.
i. Develop a system whereby patients can get prescriptions, etc to stock (as safe and appropriate) 6 to 12-weeks worth of medications and other prescribed medical supplies to sustain them during a pandemic.
j. Establish and maintain avenues for communicating with Panhandle Health District to remain informed about pandemic influenza, triage and screening protocols to be used and plans for referral of sick persons.

k. Exercise facility communication and coordination with Panhandle Health and other health care partners.

Pandemic Period

a. Activate plans for continuity of operations.
b. Monitor HAN alerts, triage protocols, referral guidelines and treatment protocols issued by Panhandle Health and the Centers for Disease Control.
c. Notify Panhandle Health with information on suspected or confirmed cases of a novel influenza virus.
d. Provide referrals for hospitalization or to alternative influenza care centers as directed by protocol.
e. Assist in providing antiviral medications and/or immunizations in accordance with public health guidelines when resources become available.
f. If no longer able to sustain independent operations, contribute to staffing of hospitals and alternative influenza care centers.

C. Individual Practices

The responsibilities and challenges of individual practices will be very similar to those in urgent care clinics and group practices. The key difference is that individual practitioners will have less flexibility to maintain clinical operations during a pandemic because loss of just one or two people from a small practice can severely limit the ability to continue services.

Interpandemic and Alert Periods

a. Develop a written plan for continued operation and increased demands in the face of decreased staffing.
b. Examine the hospital care section of this plan to assess for relevant considerations.
c. Determine how to conduct internal surveillance for pandemic influenza in staff personnel and in the clients served.
d. Develop policies and procedures for managing pandemic influenza in staff.
e. Educate and train personnel on pandemic influenza, appropriate levels of infection control precautions, wearing appropriate PPE, and the practice's response plan.
f. Develop a plan for procuring the supplies such as personal protective equipment and other supplies needed to maintain and increase operations.
g. Determine how the practice will communicate with patients and assist in educating its patients regarding prevention and control measures.
h. Develop a system whereby patients can get prescriptions, etc to stock (as safe and appropriate) 6 to 12-weeks worth of medications and other prescribed medical supplies to sustain them during a pandemic.

i. Late in this period, consider completing as much preventive and recurring care as possible in advance of the pandemic period surge.
j. Establish and maintain avenues for communicating with Panhandle Health District to remain informed about pandemic influenza, triage and screening protocols to be used and plans for referral of sick persons.

Pandemic Period

a. Activate plans for continuity of operations..
b. Monitor HAN alerts, triage protocols, referral guidelines and treatment protocols issued by Panhandle Health and the Centers for Disease Control.
c. Notify Panhandle Health with information on suspected or confirmed cases of a novel influenza virus.
d. Provide referrals for hospitalization or to alternative influenza care centers as directed by protocol.
e. Assist in providing antiviral medications and/or immunizations in accordance with public health guidelines when resources become available.
f. If no longer able to sustain independent operations, contribute to staffing of hospitals and alternative influenza care centers.

D. Professional Home Care

Given the limited availability of hospital resources, as well as the risk of infecting others while in the community, much of the care for those with pandemic influenza will occur in the home. The majority of this care can and should be provided by family and friends, but not everyone will have caregivers to provide such care and others will require home care for other medical needs such as existing health care needs or associated with early discharge from a hospital. Still others will be too sick for family care yet lack a hospital bed or alternative influenza care center to which they can be admitted. In these cases, professional home care may be required in the absence of suitable alternatives. The goals of such care will be:

- Prevent the spread of infection to the caregiver and others in the community
- Manage influenza and non-influenza care issues in the most effective way possible outside a hospital setting.
- Consult with physicians, as appropriate, to ensure the proper level of care and to determine when admission to a hospital is required.

Interpandemic and Alert Periods

During this period, agencies that provide or will provide home health care should:

a. Develop a written plan for continued operation and increased demands in the face of decreased staffing.

b. As part of the plan, determine if the agency will assist in caring for influenza patients at home or only those discharged early from hospitals as part of hospital management of bed flow.
c. Determine the number of additional clients/patients that might be cared for.
d. Notify Panhandle Health of agency initial determinations of b. and c. above.
e. Determine how to conduct internal surveillance for pandemic influenza in staff personnel and in the clients served.
f. Develop policies and procedures for managing pandemic influenza in staff.
g. Educate and train personnel on pandemic influenza, appropriate levels of infection control precautions, wearing appropriate PPE, and the organization's response plan.
h. Develop a plan for procuring the supplies, such as personal protective equipment and other supplies, needed to maintain and increase operations.
i. Determine how the agency will communicate with clients during a pandemic and assist in educating existing patients regarding prevention and control measures.
j. Develop a process to assist existing clients in obtaining prescription medications and medical supplies to stock (as safe and appropriate) to meet the needs of a 6 to 12-week period of time during a pandemic.
k. Late in this period, consider completing as much preventive and recurring care as possible in advance of the pandemic period surge.
l. Establish and maintain avenues for communicating with Panhandle Health District to remain informed about pandemic influenza and protocols to be used for treatment and referral.

Pandemic Period

a. Activate plans for continuity of operations and expansion.
b. Notify Panhandle Health with information on suspected or confirmed cases of a novel influenza virus if discovered in conjunction with visits to existing clients.
c. Notify Panhandle Health with updated numbers of additional clients that can be assisted.
d. Remain in contact with Panhandle Health to obtain the most current information on the pandemic.
e. Implement infection control measures:
    1) Limit contact between infected and not infected persons:
        a) Physically separate the patient(s) with influenza from non-ill persons living in the home as much as possible.
        b) While likely not able to do so in this circumstance, patients should not leave the home during the period when they are most

likely to be infectious (5 days after onset of symptoms, and potentially longer).
   c) To the extent possible, one person should be the designated caregiver and all others should limit contact.
   d) If contact between infected and not infected individuals cannot be avoided ensure a surgical or procedure mask is worn over the nose and mouth of the ill person, and open the windows to increase air circulation.
2) Avoid exposure to infectious respiratory secretions:
   a) Cover nose and mouth when coughing or sneezing.
   b) Use tissues to contain respiratory secretions.
   c) Dispose of tissues in the nearest waste receptacle after use.
   d) Perform hand hygiene after contact with respiratory secretions and contaminated objects/materials.
3) Persons caring for individuals suspected to be infected with influenza should protect themselves by:
   a) Wearing a surgical or procedure mask when in close contact (< 3 feet) with an infectious person. Masks should be changed and discarded when they become moist. Wash hands or use alcohol based hand rub after touching or discarding a mask.
   b) Wearing gloves if there is likely to be contact with respiratory secretions. Discard gloves immediately after use.
   c) If hands are visibly soiled, wash them with warm water and soap.
   d) If hands are not visibly soiled, use an alcohol-based hand rub, if it is available since it doesn't dry the skin.
   e) Perform hand hygiene after contact with a person who may be ill, after removing mask or gloves, or after touching items or surfaces that may be soiled.
4) Promote air circulation and keep environment clean to decrease spread.
5) Tissues used by the ill person and other waste should be immediately placed in a bag and disposed of with other household waste.
6) Laundry may be washed in a standard washing machine with warm or cold water and detergent, but should be handled before washing with gloves and hands washed after handling.
7) Soiled dishes and eating utensils should be washed either in a dishwasher or by hand with warm water and

soap. Separation of eating utensils used by a patient with influenza is not necessary.

8) Surfaces can be cleaned using normal procedures and household detergents.

f. Contact Panhandle Health or designated physician for referrals for hospitalization or to alternative influenza care centers as directed by protocol.
g. Assist in providing antiviral medications and/or immunizations to home clients in accordance with public health guidelines when resources become available.

E. Family and Personal Home Care

The majority of home care will be provided by family members or friends. Careful attention will need to be maintained to protect others in the household that are not yet infected. Some easy to use aids are included, but the individual or family should generally observe the following steps:

Interpandemic and Alert Periods

a. Develop a home plan to enable family members to be able to remain at home for two weeks or more without the need for public contact.
b. As part of the plan, store food, water, medications, and other family needs.
c. Contact family physician if necessary to obtain needed medication.
d. Consider completing as much preventive and recurring care as possible in advance of the pandemic period surge.

Pandemic Period

a. If a family member becomes infected:
    1) Limit contact between infected and not infected persons:
        a) Physically separate the sick individual(s) with influenza from non-ill persons living in the home as much as possible.
        b) Infected persons should not leave the home during the period when they are most likely to be infectious (5 days after onset of symptoms, and potentially longer).
        c) If infected persons must leave the home, they should wear a mask to protect others.
        d) To the extent possible, one person should be the designated caregiver and all others should limit contact.
        e) If contact between infected and not infected individuals cannot be avoided ensure a surgical or procedure mask is worn over the nose and

mouth of the ill person, and open the windows (weather permitting) to increase air circulation.

2) Avoid exposure to infectious respiratory secretions:
    a) Cover nose and mouth when coughing or sneezing.
    b) Use tissues to contain respiratory secretions.
    c) Dispose of tissues in the nearest waste receptacle after use.
    d) Perform hand hygiene after contact with respiratory secretions and contaminated objects/materials.
3) Persons caring for individuals suspected to be infected with influenza should protect themselves by:
    a) Wearing a surgical or procedure mask when in close contact (< 3 feet) with an infectious person. Masks should be changed and discarded when they become moist. Wash hands or use alcohol based hand rub after touching or discarding a mask.
    b) Wearing gloves if there is likely to be contact with respiratory secretions. Discard gloves immediately after use.
    c) If hands are visibly soiled, wash them with warm water and soap.
    d) If hands are not visibly soiled, use an alcohol-based hand rub, if it is available since it doesn't dry the skin.
    e) Perform hand hygiene after contact with a person who may be ill, after removing mask or gloves, or after touching items or surfaces that may be soiled.
4) Promote air circulation and keep environment clean to decrease spread.
5) Tissues used by the ill person and other waste should be immediately placed in a bag and disposed of with other household waste.
6) Laundry may be washed in a standard washing machine with warm or cold water and detergent, but should be handled before washing with gloves and hands washed after handling.
7). Soiled dishes and eating utensils should be washed either in a dishwasher or by hand with warm water and soap. Separation of eating utensils used by a patient with influenza is not necessary.
8) Surfaces can be cleaned using normal procedures and household detergents.

b. Provide supportive care.
    1) Use acetaminophen or ibuprofen to control fever. Except in children, fever is not a hazard, but relieving fever will make the ill person feel much better.

2) In infants under 2 months of age, for patients who are severely immunocompromised and in those who have a reoccurrence of fever after a well period medical attention should be sought immediately.
3) Avoid dehydration by providing and encouraging fluids.
    a) Signs of dehydration include dry mouth, dry and sunken eyes, and decreased urine output.
    b) The best fluids are commercially prepared mixtures such as Pedialyte or sports drinks, but if these are not available, a recipe for "home-made" mixtures is included. Care must be taken in making these mixtures since if done incorrectly, they can cause harm by worse dehydration.
    c) Do not consume alcoholic beverages because these can worsen the dehydration.
    d) If unable to drink, even frequent sips of fluid, health care consultation and possible treatment must be sought.
4) Nasal decongestants (e.g., pseudoephedrine), expectorants (e.g., guaifenesin), and cough suppressants (e.g., dextromethorphan) will help relieve symptoms and improve comfort, but will not shorten the course of the disease. (Persons with high blood pressure should take great care in using pseudoephedrine.)

c. Know how to get more help
1) Those with chronic illnesses or who are pregnant need to remain in close contact with the providers caring for them.
2) If any of the following are evident, it is important to contact the health care advice line at _____ or a health care provider if the ill individual has one.
    a) Fever in patients under 2 months of age.
    b) Fever in someone who is immunocompromised.
    c) Fever not controlled by medications.
    d) High fever continuing more than 3 days, or reappearing after a prolonged period without fever.
    e) Signs of dehydration (dry mouth, dry eyes, decreased urine output, doughy or loose skin, rapid heart rate (without a fever)).
    f) Wheezing or difficulty breathing.
    g) Shortness of breath.
    h) Signs of respiratory distress (e.g., grunting, nasal flaring, retractions of the chest wall)
    i) Coughing up bloody material.
    j) Chest pain (other than only when coughing).
    k) Croupy cough.
    l) Severe ear pain or severe muscle pain.
    m) Changes in mental status, irritability.

n) Protracted vomiting.

XIII. ALTERNATIVE INFLUENZA CARE CENTERS

A. Purpose

Alternative Influenza Care Centers (AICC) are locations that have not been specifically designed for the provision of health care, but which will be utilized for the provision of non-hospital basic services. In a pandemic, it is likely that hospitals will reach capacity between the second and third week of the local outbreak. At this point, some provision will be needed for those who cannot remain at home, but also cannot be accommodated by a hospital.

The initiation and use of the AICC will be specifically designed to alleviate pressure on hospitals which must be maintained as sources of critical care services. Care provided at these AICC locations cannot be provided at the same standard as that in purpose-built health care facilities, but cohorting of influenza patients and concentrating of staffing resources may facilitate the ability to provide the greatest level of care to the greatest number of patients.

Throughout the course of an influenza pandemic, the primary location for care of persons with presumed influenza will be the patient's home and their primary providers of care will be family members or friends. Many aspects of this plan are designed to enable the majority of ill persons to remain home.

Despite these efforts, it has been identified that up to 24 percent of persons in some studies do not have anyone to provide care for them if they were to become too ill to care for themselves. Some jurisdictions have proposed a "buddy system" or other means of attempting to ensure that caregivers are available to those in need, but these have met with limited response and, in the face of an infectious disease with potentially fatal consequences, the likelihood of success of these programs is uncertain.

The AICC may perform several functions including:

1. An alternative to hospital admission for those too ill to remain at home.
2. Providing care for those with inadequate resources for home or self care.
3. Enabling a potential site of care for those who can be discharged from the hospital, but who are unable to return to a home setting.
4. Cohorting persons who are infected or believed infected with influenza in a common facility away from patients requiring care for other reasons.
5. Providing a site for evaluation of potential influenza patients separate from and instead of the emergency department.

The AICC will necessarily provide a standard of health care commensurate with the available level and type of resources. The level may be primarily supportive or

may become more advanced depending upon the level of staff and their expertise, as well as supplies available.

B. Command and Control

Alternative Influenza Care Centers will be under the primary oversight of an associated hospital. While it will not be possible to provide hospital-level care in these facilities, health care organization oversight provides care expertise, the use of protocols developed by the hospital to assess patients and govern admissions and the potential to bill for services provided enabling a degree of facility and staff reimbursement.

Command and control for the AICC will be patterned after the Hospital Incident Command System (HICS). Job action sheets for defined positions are in the aids to this section.

C. Selection of Alternative Influenza Care Centers

Alternative care centers will be determined upon the following characteristics:

1. Space for required bed capacity with spatial separation of patients, including adequate room for equipment and to enable movement of patients on gurneys and wheelchairs.
2. Restroom and shower facilities to accommodate the patients admitted.
3. Facilities and supplies for hand hygiene.
4. Environmental control to provide adequate heating, cooling and ventilation.
5. Ability to provide safety and security.
6. Adequate space to secure supplies.
7. Food services (refrigeration, food handling and preparation).
8. Availability of environmental supplies (linen, laundry, waste.)
9. Existing or available staffing for patient care and support services.
10. Cleaning/disinfection supplies.
11. Space for collection of deceased bodies.

While hospitals and skilled nursing facilities meet these characteristics, they will not have the capacity to directly provide these capabilities; however they may have associated nearby structures that might provide a majority of these characteristics. The next most functional facilities would be hotels that already provide many of the non-medical requirements identified above. Other facilities of opportunity would include school gymnasiums, armories, fairground buildings and other facilities that would contain as many of these identified characteristics as possible.

As noted, hotels would offer the most functional structures other than those that are dedicated inpatient health facilities. Beds are already in place, with restroom facilities for each room and special separation can be assured. Many contain food preparation facilities and all have significant linen supplies. They are also

equipped with housekeeping supplies and most have electronic entry systems that offer a degree of safety and security. Selected facilities should be in proximity to hospitals to limit transport needs and to facilitate the sharing of resources. The largest hotels possible should be selected to maximize the efficient use of staffing and supplies.

D. Staff at Influenza Care Centers

The single greatest challenge, and the primary limiting factor, to development of the Alternative Influenza Care Centers, will be the available number of healthy and competent and health care professionals to provide care. Health care professionals will be needed to provide direct care and to provide clinical direction to other volunteer workers. The number and level of expertise of the health professionals will determine the types and level of services that will be available.

In the care of acute patients the staffing ratio will be at least one physician/practitioner per 60 patients and one licensed nurse per every 20 patients per 8-hour shift. A pharmacist or pharmacist technician will also be needed at each AICC at all times for this level of care. Additional health professionals (respiratory therapists, phlebotomists, social workers and dieticians) are desirable, but will be in limited supply. A skilled person (psychiatric social worker, counselor or other worker) should also be present to address mental/emotional issues among patients and staff. Most of these personnel will come from Medical Reserve Corps personnel, staff from small practices that have closed or from hospital personnel that can be reassigned.

Unlicensed staff and those with no background in the provision of direct patient care will be drawn from among volunteers provided just-in-time training and will be directly supervised in the care of patients.

Hotel and facility staff normally assigned to janitorial duties, food preparation duties and housekeeping duties will be asked to continue in these functions while the AICC is in operation.

E. Supplies at Influenza Care Centers

The medical supplies needed will both depend upon and limit the type of services to be provided. Intravenous fluids, intravenous catheters, tubing, etc will need to be provided through hospital acquisition processes or, less likely, may be available through the strategic national stockpile. Oral hydration solutions are commercially available, and may be obtained through retail suppliers. Personal protective equipment (PPE), gurneys, cots/beds, durable medical equipment, etc., may be obtained from medical supply companies or redirected from caches under the control of the American Red Cross or the hospitals themselves.

Pharmaceuticals, both prescription and over-the-counter medications, will be in demand for both influenza and pre-existing conditions. Supplies will come from hospital suppliers, local pharmacies, state supplies and the Strategic National Stockpile, if available.

Hotels with attached or associated restaurants will have limited on-hand foodstuffs and janitorial/housekeeping supplies. These items will need to be restocked over time.

F. Operations

1. Admission to the AICC

Admission to the AICC must be controlled and is a part of the continuum of care from home to hospital. Admission will occur following evaluation of patient medical status and health care need. It will be primarily protocol driven with those protocols developed or approved by the associated health care facilities and shared with other regional facilities for information and comparative purposes.

The two general categories of patients to be admitted to the AICC will be:

a. Persons normally requiring hospital level care, but not ill enough to meet the hospital admission criteria in effect at the time.
b. Persons less ill, but with insufficient home-based resources, who need assistive care.

AICC admission will be by referral from community health care providers in keeping with protocols distributed via the Health Alert Network through the Panhandle Multi-agency Coordination Group at Panhandle Health. Alternatively, admission will be through referral from health care facilities also in keeping with developed and published protocols. Home health professionals caring for individuals will be knowledgeable in the current admission criteria and will contact their consulting physician for admission referral.

2. Infection Control Measures

Universal, respiratory and droplet precautions will be maintained and disinfection procedures will be performed. Use of PPE will be mandatory.

One staff member will be designated as the Infection Control Officer, but infection control will be the responsibility of all individuals.

3. Facility Use

Hotels

If a hotel is utilized, the guest rooms may be utilized for individual patients. Since fewer patients may be cared for in this type of arrangement and more staff are required, while it may be counterintuitive to do so, patients that are requiring less intensive care should be cared for in these areas as opposed to communal areas. Unlike hospitals, hotels lack a nurse call

system and therefore it may be appropriate to care for more stable patients in this setting. These rooms would serve well for those who do not have someone to care for them at home, yet do not require an intensive level of care. In addition, these rooms may serve as a good location for individual care for those who had been hospitalized for non-influenza reasons and are not yet ready to go home, but no longer require a hospital bed. Environmental systems permitting, patients in these different categories could be cared for on different floors and by different staff. A room or rooms at the center of the hallway would be set aside as a nursing station and medication/supply room. Rolling platforms could be used as documentation stations. In addition, many hotels are now equipped with wireless enabling the potential for online documentation, automatic communication with the base hospital, and other sophisticated personnel, bed and supply tracking capabilities. Since some hospitals are also using wireless, it may be able to use some of these same systems tailored for remote access.

Large areas, such as convention and meeting rooms, may serve as group treatment areas. A sample diagram of this configuration is included in the aids. Proper spacing of beds is essential and some mobile privacy curtains should be provided to enable a degree of privacy while procedures are being done and for those requiring use of bedpans, catheters and sponge baths. This open bay type of care will enable the most efficient use fo the limited staff available. Only patients confirmed to have influenza would be cared for in this area. Pediatric patients might be further cohorted to a separate area due to special management needs and to allow for better rest of others.

Other Facilities of Opportunity

Other facilities that might be utilized will have variably capability and resources obtained externally will need to be tailored accordingly. In almost all cases, care will be in group settings with modifications of the 20 patients per nurse core concept. It must be kept in mind that this level of staffing is based upon patients requiring basic care. It also must be noted that this single nurse must be augmented by aides providing the bulk of hygiene and other personal care while allowing the nurse to provide the necessary acute medical care.

4. <u>Other Considerations</u>

    a. Lifts, wheelchair access and other accommodations may be needed depending upon the type of population to be served at the AICC.
    b. Similarly to bedded facilities, translation services, spiritual support, social work and other services may be necessary for this population.

XIV. PATIENT MANAGEMENT

Providing consistently effective treatment and disease management throughout the Idaho panhandle for individuals who become infected with pandemic influenza will be both challenging and crucial to ensuring the greatest survival possible in a situation of high demand and limited resources. While individual clinical judgment will play a key role in the care of individual patients, clinical guidelines will aid providers of care in diagnosing, triaging and optimally treating patients with this never-before-seen disease. This will aid in ensuring that, regardless of where one is treated, there can be a common expectation of a standard of care even under pandemic conditions.

Equally importantly, guidelines/protocols for diagnosis and care provide the greatest chance of identifying cases of a novel influenza virus as early as possible. This will provide what little time there may be for an effort to be made to limit the spread of disease and minimize the number infected.

A. Role of Panhandle Health District

1. Education and Notification

During both the alert and pandemic periods, Panhandle Health District will take an active role in educating healthcare providers about novel and pandemic influenza infections, and about their role in addressing the needs of affected patients and communities. Panhandle Health will provide notification to health care providers and facilities using the Health Alert Network (HAN) as well as through whatever other means necessary.

Interpandemic and Early Alert Periods

a. Maintain and test the Health Alert Network to provide immediate notification of changing events both prior to and during a pandemic.
b. Provide current information on development of any novel influenza viruses, period information on cases occurring worldwide and the status of treatment and prevention measures related to each virus.
c. Report changes in WHO Phases along with context on what the changes mean locally.

Late Alert Period (WHO Phase 5)

a. Provide the current case definition related to the virus that is responsible for the clusters of infections occurring.
b. Provide ongoing updates regarding laboratory diagnosis, availability of rapid tests, effective antiviral agents and reporting requirements.

Pandemic Period

a. Provide the current case definition for the responsible viral infection.

b. Provide guidance on current laboratory testing for the responsible virus.
c. Provide updated reporting requirements.
d. Disseminate current treatment information including effectiveness of antiviral medications.

2. Case Definitions

The diagnosis of illness caused by any novel influenza virus will be directly dependent upon provider awareness of the case definition of an infection. Currently the case definition of the influenza virus of concern is based upon cases worldwide caused by the H5N1 virus and is published by the World Health Organization. The current case definition is located in the appendix to this section. Panhandle Health District will be responsible for remaining aware of and disseminating the current case definition to health care providers through the Health Alert Network.

3. Triage Protocols

While each treating facility may likely have slight variations in its triage protocols, it is important that such protocols are essentially uniform across the region. This will prevent confusion among responders, promote cooperation among health care facilities and create common expectations among the public.

While it is possible to have a proposed triage protocol in advance, the nature of the illness itself in terms of its behavior, severity and speed of reaching epidemic numbers in patients will govern modification.

One example of a triage model is included in the appendix to this section. Panhandle Health, through the Panhandle Multi-Agency Coordination Group, will coordinate a triage model for review and adoption by the participating health care organizations. Updates will likewise be coordinated through the PMACG.

4. Clinical Treatment Protocols

Panhandle Health will not define treatment protocols, but will identify any changes in recommendations developed by the Centers for Disease Control. PHD will also serve as publisher of protocols that are agreed upon by members of the PMACG and provide the protocols to all PMACG members and community providers of care.

B. Current Guidance for Clinicians

1. Diagnosis of Patients With Novel or Pandemic Influenza Virus Infections

Alert Periods

It is unlikely that novel or pandemic influenza will appear in northern Idaho during the alert period, however, once a pandemic has begun, the crossroads and tourism nature of this region will make it likely that the illness will arrive relatively soon.

The expectation that arrival may be delayed makes it all the more critical that clinicians are vigilant to the possibility that influenza-like illness, particularly aberrant in behavior or occurring outside the normal seasonal context of expected influenza, may represent early arrival of a novel influenza virus. Epidemiological context will be a key component of diagnosis as a potential novel virus, H5N1 or early pandemic influenza case.

A complete current case definition may be found at the beginning of the appendix to this section, but in general the following patients should currently be evaluated for the possibility of infection with H5N1 influenza:

Hospitalized patients with:

1. Radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established.

AND

2. History of travel within 7 days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans

OR

Hospitalized or ambulatory patients with:
1. Documented temperature of >38 degrees C (>100.4 F) with cough, sore throat and/or shortness of breath

AND

2. History of contact with poultry (e.g., visited a poultry farm, a household raising poultry, or a bird market) or a known or suspected human case of influenza A (H5N1) in an H5N1- affected country within 7 days of symptom onset.

If these criteria are met suggesting the possibility of H5N1 infection, health care providers should immediately:

a. Implement infection control precautions.
b. Report the case to Panhandle Health District Epidemiology.
c. Obtain and submit clinical specimens for novel influenza A infection as directed by Panhandle Health.
d. Initiate antiviral treatment, if available.
e. Triage to the appropriate level of care.
f. Still consider appropriate alternative diagnoses.

g. Provide necessary clinical management services, unless the patient has been admitted for inpatient evaluation and care.
h. Assist Panhandle Health in identification of potentially exposed contacts, as needed.

Pandemic Period

Once it has been established that a pandemic strain of influenza is circulating in the population of northern Idaho, diagnosis of pandemic influenza will be based primarily on clinical criteria. Any case of influenza-like illness during that time period will be likely be pandemic influenza, so less emphasis will be placed on establishing an epidemiological risk factor. Routine diagnostic laboratory testing to confirm infection with pandemic influenza will no longer be indicated to guide management in most situations.

2. Infection Control

a. Health care providers should at all times maintain rigorous infection control measures commensurate with any virus that is highly contagious and transmitted by the respiratory route.
b. If a case of a novel influenza virus is suspected, isolation of that patient until confirmation of diagnosis or disposition of the patient to a proper location has occurred.

3. Diagnostic Testing

Rapid influenza diagnostic tests have relatively low sensitivity for detecting seasonal influenza. Given this and their questionable ability to detect a novel influenza virus, such tests should not be used to confirm or exclude novel influenza infections. In all case specimens should be forwarded for definitive diagnosis.

4. Initiation of Antiviral Therapy

When initial suspected cases are identified, there may be limited amounts of antiviral medications locally available to provide treatment. Only neuraminidase inhibitors should be used since other agents have been shown to be ineffective.

It is critical that confirmed initial cases are identified to Panhandle Health District. There is a limited supply of antiviral medication stockpiled specifically to treat early cases and provide prophylaxis to contacts in an effort to forestall further cases locally and contain the outbreak.

5. Triage to Appropriate Levels of Care

Early cases will be treated in accordance with existing standards of care relative to a highly infectious respiratory disease. Providers will need to determine if the degree of illness merits hospitalization and negative pressure isolation, but care at home should remain an option as it would

with any illness. If care at home is elected, isolation of the individual should be ensured in order to prevent transmission to others.

When the pandemic has begun, home care will be the modality of choice unless the degree of illness absolutely requires otherwise. At that point, triage will occur to the appropriate level of care based upon the resources available i.e. hospital versus alternative influenza care center.

6. Patient Management

Patients should be managed symptomatically in accordance with sound medical principles. Any unique treatment requirements related to the novel virus will be published at the time that such characteristics become evident.

XV. PSYCHOSOCIAL SUPPORT

A. Overview

While models exist for post traumatic psychosocial support, there is limited experience with prolonged, widespread and fluctuating situations in which the threat of mortality is persistent. Even in large events, such as those related to hurricanes, stress may persist, but the cause of the disaster itself and the immediate threat to life is of finite duration. The effects of a pandemic may last for years and, unlike most disaster situations, could potentially have a disproportionate risk for those most needed to provide health care and critical subsistence support. Critical infrastructure and health care workers will need to continue to work while family members are potentially becoming ill, or even dying. In addition, due to the globalization of food and material goods supplies, ongoing waves of the pandemic will affect local standards of living to an extent never before seen.

Critical to success in this environment is advanced education and planning to enable the greatest individual and family preparation possible and to prepare the public and healthcare professionals for the potential life-changing events that they may face. Ongoing support during the pandemic itself will be important, but will be inherently limited by the availability of personnel and their needs to care for their own families.

Unlike some health departments, Panhandle Health has no employed mental health resources. Reliance must be on private resources and, to a limited degree, on Department of Health and Welfare local resources.

B. Purpose

The purpose of this chapter is to provide a framework for psychological preparation of both the public and healthcare workers for an influenza pandemic and support both during the event itself and in the period of recovery.

C. Assumptions

1. A pandemic associated with mass casualties, restrictions on activities, individual and family isolation, scarcity of supplies and the constant threat of infection and death will result in significant psychological reactions throughout the community.
2. Persons with pre-existing mental health conditions will have increased difficulties under these circumstances.
3. Healthcare workers, who will be faced with difficult care decisions, the increased personal threat of disease, ongoing concern about family welfare and potentially chronic fatigue, will be at increased risk for stress reactions and more significant psychological disorders.
4. Psychological difficulties, in the form of Post Traumatic Stress Disorder, will persist well after the pandemic has passed.
5. Disease rates in mental health professionals will be on par with those in other health professions.

D. Scope

Given the expectations described above, it will be important to provide general support for the public, targeted support for those currently under care and tailored support for the healthcare community. This must begin well in advance of the arrival of an influenza pandemic in the northern Idaho community in order to develop a degree of anticipation and psychological immunity and extend throughout and beyond the pandemic itself.

E. Concept of Operations

1. Identified Mental Health Clients

There are significant concerns that limitations in the availability of mental health providers will disrupt the continuity of essential mental health care for current mental health clients and severely limit care for those having newly identified serious psychiatric illness. These may be among the most vulnerable in society since ongoing health may be highly dependent upon the continued availability of mental health resources. New methods must be used in an effort to deliver at least maintenance levels of care in the face of limited resources and the desire to prevent the spreading of infection. Primary responsibility for these clients/patients will remain with their mental health providers, but should there no longer be the availability of these services or new patients become excessive, public resources will need to provide assistance. The existing Panhandle Health District Mental Health Plan which calls upon a partnership of Panhandle Health with North Idaho Critical Incident Stress Management (CISM) and the Idaho Department of Health and Welfare Crisis Response Team will be used to establish a referral structure for this group of patients.

2. General Community

The best approach to those in the general community is to provide a form of psychological immunization as a prevention effort leading up to and

following the onset of an influenza pandemic. Panhandle Health will coordinate and disseminate educational materials on community and neighborhood-based intervention strategies for the general community, businesses and organizations during the alert and pandemic periods. The information and suggested interventions will be based on self-help strategies that can be employed by lay community members so that they can provide emotional and psychological support to those in distress when professional medical and psychological support are not available.

3. Healthcare Workers and Their Families

Addressing and alleviating the accumulated stress experienced by healthcare providers, particularly when there are not enough responders over the pandemic period, will be a high priority. Individual health care facilities have a keen interest in maintaining staffing and will be responsible for developing internal programs of staff support. By extension these programs will serve as referral avenues for community health care providers whose continued ability to care for patients is of critical importance to health care facilities as well. Panhandle Health will assist by further disseminating educational preparation for families of health care providers in order to minimize the conflict and pulls of family and professional obligations.

Interpandemic and Alert Periods

Phases 1 and 2

Ideally this would be the time for identifying populations and performing planning, but since we are already in Phase 3 and are likely not to regress from this phase, the steps anticipated for Phases 1 and 2 become included in Phase 3.

Phase 3

Mental Health Clients

a. Mental health providers should encourage their patients to maintain good hand hygiene and disease prevention practices.
b. Direct clients to information on public health resources
c. Encourage clients to get annual influenza immunizations

General Community

Panhandle Mental Health Plan Partners should:

a. Identify availability, interest and expertise of District providers of psychosocial services who may be available to contribute assistance or support leading up to and during a pandemic.
b. Identify, contact and discuss partnering with any agencies that engage in behavioral home health
c. Identify any facilities and clinical organizations that might accept overflow psychiatric client capacity
d. Develop or obtain educational materials to provide to organizations and individuals.

e. Publish available educational materials in the pandemic influenza preparedness portion of the Panhandle Health District website.

Health Care Workers

a. Health car facilities should develop specific training for health care workers, spouses and children on dealing with stress, development of coping skills, recognition of acute stress reactions and methods of limiting effects on daily living.

Phases 4 and 5

Mental Health Clients

a. Mental Health providers should provide counseling to their patients specifically about pandemic influenza and what might be expected.
b. Develop written clinical self-care plans for each client that may be homebound or will be at risk due to closure of a mental health clinic.
c. Thoroughly review these plans with the client to ensure understanding.
d. Mental health providers should determine threshold for canceling routine scheduling of therapy and medication management clients, and move toward emergency response scheduling.

General Community

a. Panhandle Mental Health Partners will organize broad community education to inform the public about an influenza pandemic and how to prepare physically and mentally.
b. Utilize mental health professional volunteers to train other Medical Reserve Corps volunteers on normal stress reactions and how to reduce the impact of them on activities of daily living.
c. Utilize these volunteers to provide education to community organizations, faith-based organizations and other groups on normal stress reactions and ways to reduce their impact.
d. Distribute mental health educational materials to police, fire, and community volunteers describing the acute reactions that are anticipated from the pandemic.
e. Incorporate information and Frequently Asked Questions into the Panhandle Health website in cooperation with mental health partners.

Health Care Workers

a. Teach staff to distinguish between psychiatric disorders and common reactions to stress and trauma in patients, how to deal with the worried well and how to look for such reactions in each other.
b. Conduct briefings for staff on behavioral health, stress management issues, and coping skills

c. Train facility supervisors in ways of maintaining a supportive work environment

Pandemic Period

Phase 6

Mental Health Clients

a. Individual mental health providers should maintain services and contact with their patients as long as possible
b. Implement tele-counseling and other remote services where and when appropriate in an effort to minimize the potential spread of disease.
c. If illness compromises the ability to directly provide services, mental health providers should have an alternate provider designated to cover as long as possible.
d. If services are no longer available, primary reliance will be on the previously developed self-care plans
e. Ensure patients have a telephone number for contact to all individuals and clinics available, as well as to the

Idaho Suicide Prevention Hotline
1-800-564-2120

General Community

a. Encourage community and faith-based organizations, particularly those that have established Community Assistance Centers, to provide talk lines and, where possible, to make home visits to homebound ill individuals at particular risk for acute negative stress reactions to the pandemic.
b. Provide a mental health professional to the regional hotline as a resources for triage and referral. This individual will not be for the primary purpose of providing telephone therapy.
c. Continue, through public service announcements and website postings, to provide information to alleviate fears as the pandemic progresses.

Health Care Workers

a. Health Care organizations provide ongoing monitoring and support for employees.
b. Refer staff to behavioral health services upon request
c. Provide outreach to employees' families to address ongoing psychological and social issues
d. Make available services to health professionals in the surrounding areas.

XVI. MAINTAINING ESSENTIAL SERVICES

A. Overview

The definition of essential services typically includes emergency medical services, law enforcement and fire services, but under circumstances such as those during an influenza pandemic, others not commonly though of as essential become of great importance.

In the circumstances of a pandemic, essential services will include those that:

- Must support basic necessities and social needs
- Are responsible for critical health care and emergency services
- Are necessary to minimize deaths and hospitalizations

Though of critical importance to the community, each organization must be responsible for its own continuity of operations planning since no external person or group can have the necessary appreciation of its mission and the complexities required for continued function in the face of reduced staffing and resource limitations.

B. Purpose

While each organization has individual responsibility for continuity of operations planning (COOP), this plan is to serve as a reference to provide background information on pandemic influenza, disease prevention, infection control and, in the accompanying appendix, checklists published by the Department of Health and Human Services provide guidance on organizational planning.

C. Essential Services

While lists may vary, the following is a list of likely essential services and why they would be viewed as such:

1. Emergency Medical Services (EMS)
   Critical for first response regardless of medical cause. In a pandemic, trauma and other medical emergencies will continue. EMS is also critical for patient transport which will also be key in redistribution of patients.

2. Fire Service
   Essential for community infrastructure both as a fire protection organization, but also due to paramedic support provided.

3. Food Suppliers (wholesale and retail, but not restaurants)
   These wholesale and retail food suppliers are critical to basic human living.

4. Government Agencies (select)
   This applies to agencies and leaders that are essential to infrastructure support, decision making and ensuring continued social order.

5. Hospitals and Other Medical Facilities
   This includes a wide range of facility types and their associated staff. These are inherently critical to preserving life and minimizing morbidity.

6. Law Enforcement
   Critical to maintaining social order. In addition, provide 911 services for rapid response.

7. Mortuary Services
   Critical for remains management and supplying expertise that will be necessary in managing potentially sudden large numbers of deceased.

8. New Media Organizations
   Not all media will be essential, but those that provide support for risk communications with the public are a key component of pandemic response.

9. Public Health Agencies
   This refers specifically to Panhandle Health, but also to Idaho Department of Health and Welfare services that are critical to pandemic response.

10. Utility Services
    These are critical to meet basic human needs as well as to support health care and the maintenance of public health through sanitation activities.

D. Concept of Operations

Multiple other parts of this plan provide numerous resources that will aid organizations in planning for physical separation of workers, implementing infection control measures and improving prevention efforts.

Each organization should develop, exercise and refine a COOP at the earliest opportunity.

Interpandemic and Alert Period

1. Assign a team, preferably of volunteers, to analyze the organization and develop a Continuity of Operations Plan. Members must include persons with the organizational experience and authority to make accurate determinations of key functions and decisions on steps that are to occur.
   a. Determine realistically what core activities can and must be sustained for an extended period despite staff shortfalls
   b. Ensure planning includes provision for:
      1) Succession in all key area
      2) Staff support
      3) Logistics for critical lines of supply and distribution
      4) Continued information management availability
      5) Communications

6) Organizational security
7) Family and personal needs

c. Consider development of cross-training programs to ensure duplication of skills in critical areas
d. Determine if remote worksites/telecommuting is an option fo some functions.

2. Institute mandatory policies for sick individuals to remain at home rather than coming to work and exposing others to illness.
3. Develop processes that enable curtailing of business travel.
4. Institute health conscious policies and processes including availability of alcohol-based hand gels and signage about hand cleanliness
5. Educate employees about these efforts.
6. Determine effective means of conduction business while minimizing the requirement for face-to-face contact.
7. Promote personal and family preparation plans
8. Encourage employees to receive annual influenza immunizations
9. Exercise the developed plan

Pandemic Period

1. Implement the plan.
2. Monitor effectiveness of actions under the plan.
3. Monitor the health and wellbeing of employees.
4. Receive and disseminate information about the epidemic received through Panhandle Health and reliable media sources.

XVII. IMMUNIZATION AND ANTIVIRAL THERAPY

A. Introduction

While the most effective therapy against a pandemic influenza would be one that immunizes individuals thereby preventing disease from the outset, it is unlikely that an effective vaccine will be generally available in the early stages of a pandemic given the required time for vaccine production and the and the uncertainty of the immunological characteristics of the novel virus that might appear as the source of the pandemic. While new technologies are being developed that promise more rapid vaccine production and research is underway to identify a universal influenza vaccine, these are likely several years from practical application.

A vaccine has been developed against the H5N1 strain, however assuming it is the cause of the influenza pandemic, there still remains a problem with production and efficacy. Each effective dose of seasonal influenza vaccine contains 45 micrograms of antigen. This is in contrast to evidence that shows that in the case of the H5N1 vaccine, two doses of 90 micrograms each are required to provide the highest immunity. Although some immune response is observed after all doses, this means that four times the antigen is required to provide consistent immunity. Studies using diluted courses of vaccine have suggested that, while some response occurs, the needed immune response will not occur at decreased doses. Since vaccine takes six months to produce, the timeline for production is a major issue. This is made even worse by the fact that since H5N1 is lethal to

chickens, it directly threatens the supply of eggs needed to make the vaccine and kills the embryos resulting in a greater number of eggs needed to generate the required amount of antigen.

As a result of these issues, immunization may be of both limited availability and limited value. Alternatively, antiviral medications provide a means of treatment of illness and of prophylaxis if used during a period of exposure. Two of the four available antiviral medications, oseltamivir and zanamivir have shown activity against the H5N1 influenza strain, but to be effective must be taken within two days of the initial flu symptoms at a time when the individual may not yet recognize they have the flu.

Although these medications show promise, they too may be in limited supply. Production of oseltamivir is reported to take six to eight months. The active ingredient is shikimic acid which comes from the Chinese herb, star anise. A synthetic version has been developed, but requires specialized fermentation equipment. In addition, the oseltamivir manufacturing process requires the use of highly reactive chemicals in a complex process. Generic versions have begun to appear, but supplies remain limited and there is a question about the development of viral resistance on some limited cases. (Andrew Pollack. "Is Bird Flu Drug Really So Vexing? Debating the Difficulty of Tamiflu," *New York Times*, November 5, 2005).

Despite these limitations, governmental authorities are making great effort to provide availability of whatever vaccine and antiviral medications might exist; however, as a result of limited supply, these resources will be initially limited to select populations.

B. Immunization

As noted earlier, the most effective method of disease prevention is through the use of a vaccine that is specific enough to the agent involved to convey significant immunity against acquiring the disease or that is close enough to the disease agent to at least result in a milder form of the disease.

When an effective vaccine is available, it will likely be in limited supply. The State of Idaho has recommended adopting the "National Vaccine Advisory Committee (NVAC)/Advisory Committee on Immunization Practices (ACIP) Recommendations for Prioritization of Pandemic Influenza Vaccine." These are outlined in the Table 1 below.

Table D-1: Vaccine Priority Group Recommendations

Tier	Subtier	Population	Rationale
1	A	• Vaccine and antiviral manufacturers and others essential to manufacturing and critical support • Medical workers and public health workers who are involved in direct patient contact, other support services essential for direct patient care, and vaccinators	• Need to assure maximum production of vaccine and antiviral drugs • Healthcare workers are required for quality medical care (studies show outcome is associated with staff-to-patient ratios). There is little surge capacity among healthcare sector personnel to meet increased demand
	B	• Persons > 65 years with 1 or more influenza high-risk conditions, not including essential hypertension • Persons 6 months to 64 years with 2 or more influenza high-risk conditions, not including essential hypertension • Persons 6 months or older with history of hospitalization for pneumonia or influenza or other influenza high-risk condition in the past year.	• These groups are at high risk of hospitalization and death. Excludes elderly in nursing homes and those who are immunocompromised and would not likely be protected by vaccination
	C	• Pregnant women • Household contacts of severely immunocompromised persons who would not be vaccinated due to likely poor response to vaccine (e.g., persons with transplants, AIDS, and incident cancer • Household contacts of children <6 month olds.	• In past pandemics and for annual influenza, pregnant women have been at high risk; vaccination will also protect the infant who cannot receive vaccine. • Vaccination of household contacts of immunocompromised and young infants will decrease risk of exposure and infection among those who cannot be directly protected by vaccination
	D	• Public health emergency response workers critical to pandemic response (assumed one-third of estimated public health workforce) • Key government leaders	• Critical to implement pandemic response such as providing vaccinations and managing/monitoring response activities • Preserving decision-making capacity also critical for managing and implementing a response
2	A	• Healthy 65 years and older • 6 months to 64 years with 1 high-risk condition • 6-23 months old, healthy	• Groups that are also at increased risk but not as high risk as population in Tier 1B
	B	• Other public health emergency responders (remaining two-thirds of public health work force) • Public safety workers including police, fire, 911 dispatchers, and correctional facility staff • Utility workers essential for maintenance of power, water, and sewage system functioning • Transportation workers transporting fuel, water, food, and medical supplies as well as public ground public transportation • Telecommunications/IT for essential network operations and maintenance	• Includes critical infrastructure groups that have impact on maintaining health (e.g., public safety or transportation of medical supplies and food); implementing a pandemic response; and on maintaining societal functions
3		• Other key government health decision-makers • Funeral directors/embalmers	• Other important societal groups for a pandemic response but of lower priority
4		• Healthy persons 2-64 years not included in above categories	• All persons not included in other groups based on objective to vaccinate all those who want protection

In keeping with this prioritization, the state will distribute vaccine received from the Federal government according to the following distribution tables:

Tier 1A Distribution

Ship-To Sites	DHD	Type	Tier 1A			Examples				
			Population	Doses Needed	% of Total*	1st month**	2nd month**	3rd month**	4th month**	5th month**
DISTRICT 1 (PUBLIC HEALTH WORKERS)	1	DHD	148	296	0.0032	73	73	73	73	3
DISTRICT 1 (OTHER HEALTH CARE PROVIDERS, EXCLUDES HOSP. STAFF)	1	DHD	2,643	5,286	0.0566	1,310	1,310	1,310	1,310	45
DISTRICT 1 (EMS RESPONDERS)	1	DHD	639	1,278	0.0137	317	317	317	317	11
BENEWAH COMMUNITY HOSPITAL	1	GEN. MED. & SURG.	146	292	0.0031	72	72	72	72	2
BONNER GENERAL HOSPITAL	1	GEN. MED. & SURG.	386	772	0.0083	191	191	191	191	7
BOUNDARY COMMUNITY HOSPITAL	1	GEN. MED. & SURG.	126	252	0.0027	62	62	62	62	2
KOOTENAI MEDICAL CENTER	1	GEN. MED. & SURG.	1,621	3,242	0.0347	804	804	804	804	28
NORTHERN IDAHO ADVANCED CARE HOSPITAL	1	GEN. MED. & SURG.	101	202	0.0022	50	50	50	50	2
NORTHWEST SPECIALTY HOSPITAL	1	OTHER: SURG. HOSP.	109	218	0.0023	54	54	54	54	2
SHOSHONE MEDICAL CENTER	1	GEN. MED. & SURG.	92	184	0.0020	46	46	46	46	2

* Calculations were rounded to the nearest 0.001.

** Based on 23,150 doses delivered to Idaho per month. Calculations were rounded to the nearest 1.0.

Tier 1B – Tier 4 Distribution

Health District	Total Population	Population Covered By Tier 1A	Tier 1B -Tier 4			Examples (Tier 1B - Tier 4)			
			Remaining Population	Doses Needed	% of Total*	Month 5**	Month 6***	Month 7***	Remaining doses needed
PANHANDLE HEALTH DISTRICT	201,570	6,011	195,559	391,118	0.1415	3163	3275	3275	381,406

*Calculations were rounded to the nearest 0.0001.
**Based on 22,356 remaining doses after Tier 1A doses are disseminated.
***Based on 23,150 doses delivered to Idaho per month.

1. Tier 1A Distribution

For Tier 1A distribution, vaccine will be sent to Panhandle Health and each named organization for them to directly administer to personnel. Since EMS responders are considered as a group rather than by individual organizations, if vaccine is delivered to Panhandle Health, PHD will administer vaccine to presenting EMS personnel based upon lists of eligible individuals provided by EMS.

2. Tier 1B – Tier 4 Distribution

While distribution recommendations may change as more is known about the pathophysiology associated with the virus causing a pandemic influenza, current guidelines provide vaccine for individuals at high risk for hospitalization and death. It will be extremely difficult to equitably distribute vaccine to healthcare providers based upon requests for certain volumes of vaccines. In addition, some providers offer immunizations in their offices while many others do not. In order to ensure the most rapid and equitable distribution of limited vaccine supplies the process will be as follows:

- All healthcare providers will be provided through HAN messaging with the eligibility criteria for vaccination in effect at the time.
- Providers will give prescriptions to those of their patients meeting criteria for immunization.
- Patients will present their prescriptions at Panhandle Health and will be administered immunization.
- Each person, upon receipt of their initial immunization (assuming two doses are required and vaccine is made available) will be given a follow-up voucher indicating when they should return for a booster dose.
- Panhandle Health will maintain a record of persons receiving immunization in accordance with this protocol.

C. Antiviral Medications

Unlike vaccines, it may be more possible to stockpile antiviral medications and to a certain degree preposition assets to be ready for a time of need. However, unlike vaccines, medications do not provide a lasting immunity and multiple courses could be needed by a given individual over the course of the pandemic, unless it were shown that treatment of early infections conveyed some degree of reliable resistance to re-infection.

Antiviral medications will potentially be available from three sources. Two programmed sources will include state-purchased antiviral medications and those potentially available through the Strategic National Stockpile. There will also be a limited amount available in commercial pharmacies as a result of supplies that are ordered annually related to treat seasonal influenza, but these cannot be considered a reliable primary source of medication.

1. Acquisition

World Health Organization (WHO) Phase 3
During WHO Phase 3, the State of Idaho will purchase/has purchased antiviral medications for distribution to health districts. These medications are for storage on site, but will not be released until WHO Phase 5 is declared.

Receipt will be as follows:

a. Panhandle Health District will sign for shipment of antiviral medications.
b. PHD will store the medications on-site at the Hayden facility under secure and environmentally controlled conditions.

WHO Phase 4
Per the Idaho State Plan, if the WHO declares Phase 4 or higher, the Governor of Idaho will declare a state of emergency and the Centers for Disease Control Division of Strategic National Stockpile (SNS) will deliver SNS antiviral medication to the State. Distribution by the health districts will occur at WHO Phase 5.

WHO Phase 5
At this point, by definition, significant human-to-human transmission of the novel influenza virus has begun. Distribution of antiviral medications by Panhandle Health District will begin consistent with treatment group restrictions and guidelines on eligibility.

WHO Phase 6
Use of medications will continue consistent with restrictions and guidelines as prescribed by the State of Idaho and the Centers for Disease Control.

2. Distribution

Use of medications will be authorized during WHO Phase 5, however use of medications will be first for treatment and then, if there is remaining medication, for prophylaxis.

It should be noted that new cases of illness will occur over a period of approximately eight weeks. Unless it is clear that further medication supplies are forthcoming, all medications will need to be reserved for treatment.

State-Purchased Antiviral Medications

Medications purchased by the State of Idaho are earmarked for two populations. The first allocation is for public health workers and their families. The following table details the distribution to Panhandle Health District.

Distribution of State-Purchased Antiviral Treatment Regimens for Public Health Workers and Their Families (ACTUAL NUMBERS DEPENDENT UPON ACTUAL REGIMENS RECEIVED AND CHANGES IN FUTURE GUIDANCE)

District	Number of Employees	Percent of Total Idaho Public Health Workers	Number of Tamiflu Treatment Regimens for Public Health Workers and Their Family Members	Number of Relenza Treatment Regimens for Public Health Workers and Their Family Members
Panhandle District Health (1)	167	17%	691	170

Source: Number of Employees for DHDs – February 2007 poll of DHDs

This provides approximately one regimen of treatment for each employee and family member of the Panhandle Health District.

The second allocation is for epidemiologic response in an effort to provide treatment of persons with suspected or confirmed infection and prophylaxis of their contacts in a effort to provide a measure of containment to prevent spread. Panhandle Health District will be allocated 500 regimens. Again, these are to be held until WHO Phase 5 has been declared.

Strategic National Stockpile Medications

As shown in the following table excerpted from State guidance, Panhandle Health District will receive a little more than 23,000 Tamiflu regimens and nearly 6,000 Relenza regimens.

Antiviral Medications Allocated from the Strategic National Stockpile for Pandemic Influenza
Based on Total Idaho SNS Allocation of 203,719
(DRAFT – DEPENDENT UPON ACTUAL REGIMENS RECEIVED AND CHANGES IN FUTURE GUIDANCE)

District	Population >=1 year of age*	Number of Tamiflu Treatment Regimens per District (Treatment for Persons Age >=1) Rounded to the Nearest 1.0	Population >=7 years of age*	Number of Relenza Treatment Regimens per District (Treatment for Persons Age >=7) Rounded to the Nearest 1.0
Panhandle District Health (1)	199,320	**23,087**	184,863	**5,872**

*** Based on July 1, 2005 Census data.**

As noted previously, **prioritized use of antiviral drugs during a pandemic influenza will be treatment and then prophylaxis.**

Per State directive, hospital medications will be utilized for the following groups and in the following order:

a. Treatment of patients admitted to hospitals with a clinical diagnosis of influenza, laboratory confirmation not required. (*National Vaccine Advisory Committee (NVAC) Recommendation Priority Group 1)*
b. Treatment of hospital health-care workers with direct patient contact and emergency medical service (EMS) providers. (*NVAC Recommendation Priority Group 2)*
c. Prophylaxis of health care workers in emergency departments, intensive care units, dialysis centers, and EMS providers. (*NVAC Recommendation Priority Group 7)*

In a severe pandemic, it is estimated that approximately 30 percent of the population will become ill, 50 percent will seek outpatient treatment and approximately 10 percent will require hospitalization. It must also be kept in mind that illness and hospitalization will occur over a period of weeks. Unless there is a guarantee of additional medications, either the initial shipment must be retained to treat individuals who become ill enough over

the course of the epidemic or there is a risk of not having sufficient medications for the most ill individuals as the epidemic progresses.

If this is the case, only 9,000 of the above noted doses will be available for care of individuals other than those hospitalized. Even fewer will remain after use for those in Priority Group 2. If Priority Group 7 is included, per State guidance, it is unlikely that doses will be available for further distribution.

In accordance with the State of Idaho plan, additional medications needed will either be directly purchased if available from pharmaceutical suppliers or will be requested by the State through the SNS process.

Additional Medications

Should medications be available, Panhandle Health District will be responsible for ensuring medications can be provided to the following priority groups in the order listed. The specific groups that will receive medications at any given time will depend upon on medication availability and State/Federal guidance.

- Treatment of highest risk outpatients – immunocompromised persons and pregnant women. *NVAC Recommendation Priority Group 3*
- Treatment of pandemic health responders (public health, vaccinators, vaccine and antiviral manufacturers), public safety (police, fire, corrections), and government decision-makers. *NVAC Recommendation Group 4*
- Treatment of increased risk outpatients – young children 12-23 months old, persons ≥ 65 years old, and persons with underlying medical conditions. *NVAC Recommendation Priority Group 5*
- Post exposure prophylaxis for outbreak response in nursing homes and other residential settings. *NVAC Recommendation Priority Group 6*
- Treatment of pandemic societal responders (e.g., critical infrastructure groups such as utility workers, transportation workers, telecommunications/IT for essential network operations and maintenance, funeral directors/embalmers) and health care workers without direct patient contact. *NVAC Recommendation Priority Group 8*
- Treatment of other outpatients diagnosed with influenza. *NVAC Recommendation Priority Group 9*
- Prophylaxis of highest risk outpatients. *NVAC Recommendation Priority Group 10*
- Prophylaxis of other health care workers with direct patient contact. *NVAC Recommendation Priority Group 11*

This process would occur as follows:

During WHO Phase 4

a. Panhandle Health will establish Memoranda of Agreement for dispensing with a network of pharmacies with at least one in each outlying county and multiple in population centers. The MOA would specify that participating pharmacies would:
    1) Receive medication free of charge and prepackaged from Panhandle Health.
    2) The pharmacy would not charge for the medication or, if necessary, would charge only a nominal handling fee of no more than an agreed upon amount for administrative handling only.
    3) Agreement that no one would be denied medication for inability to pay (or alternatively PHD could agree to cover dispensing cost incurred limited to the flat rate agreed upon).
    4) Medication would be dispensed only with a properly completed prescription bearing the signature of a known eligible provider and for authorized indication.
    5) Pharmacies would provide dispensing data to Panhandle Health on the provided electronic (or hardcopy) spreadsheet.
    6) Hardcopy of the prescriptions themselves would be retained for collection by PHD for review and archiving.
    7) Pharmacies would report any identified misrepresentations or overt fraud to Panhandle Health.
b. Panhandle Health will distribute via the HAN and/or other means to providers and pharmacies the following:
    1) Instructions for the process to be used indicating that persons meeting the defined criteria should be given prescriptions to take to the designated pharmacies for dispensing free of charge or for a nominal fee.
    2) A listing of pharmacies that have agreed to participate.
    3) A copy of the NVAC Priority Group Guidelines and representation of the prescription to be used.

WHO Phase 5

a. Panhandle Health would deliver medications to the contracted pharmacies with volumes based upon population served and anticipated volume.
b. Volumes delivered would be limited by available medications, since the bulk of early medications would have been distributed to hospitals.
c. Initial deliveries would be for one-third the available medications, to allow for readjustment based upon actual demand.
d. Panhandle Health would publish to health care providers and area pharmacies via the HAN and/or other means current case

definitions, the NVAC Priority Group Classification, the two-sided prescription form and the current eligible priority guidance.

e. Outpatient healthcare providers would evaluate patients and prescribe medications according to provided guidelines identifying on the prescription itself the indication for medication.
f. Patients would present the prescriptions (preferably along with some form of identification) at the designated pharmacies for filling.
g. Caregivers would be able to collect medications if they can identify themselves with proper identification.
h. Pharmacy personnel would be required to wear appropriate PPE during this process to minimize the risk of becoming exposed themselves.
i. The pharmacy would perform activities in accordance with the agreement above and report information on a daily basis to Panhandle Health in order to ensure appropriate resupply if medications are available.
j. Medication usage by each pharmacy will be monitored by PHD with redistribution as necessary.

XVIII. PROVIDING FOR SPECIAL POPULATIONS

Individual areas of this plan contain information regarding considerations for those populations with special needs. This section provides additional information relative to these, but also includes consideration for other populations and the challenges specific to circumstances involving pandemic influenza given its rapid and easy communicability.

Certain groups of people are more vulnerable to the impact of infectious disease than others either because of their personal health circumstances or because they live under conditions that place them at risk. Some people may live under crowded conditions that would predispose them to acquiring the disease. Others may be part of groups that experience barriers to societal resources. Still others may not seek care until late in the course of an illness making intervention less effective and unintentionally allowing greater time for communication of the disease to others. There are those who have chronic disease and are therefore inherently more vulnerable. There are even those that are at greater risk simply because of their temporary situations. Many of these groups overlap in the types of interventions that may be required, but their specific needs must be a part of the planning process.

A. Persons Dependent on Support Services

These will include a variety of groups that receive regular social support services typically of a public nature or of a private nature acting as a public service. Their commonality resides in the severity of impact that will occur if there is a disruption of the regular services they require.

1. Disabled

Depending upon the nature of the disability, persons in this group may require as little support as the availability of disabled-access public transportation systems while others may require in-home care to assist with the activities of daily living.

Interpandemic Period - Phase 1 and 2

a. Identify populations at risk with contact information – These have been identified and detailed in the Panhandle Health Preparedness and Response Plan.
b. Ensure development of Continuity of Operations Plans (COOP) – COOPs should be developed for agencies that provide essential services to assure that at least a minimal level of services can be maintained.

    1. In-home health care services for those unable to provide personal care.
    2. Minimal transportation services to ensure the ability to get to health services, if necessary
    3. Home oxygen companies to ensure adequate supplies

Alert Period - Phase 3, 4 and 5

a. Exercise and refine COOP
b. Develop individual emergency care plans and teach people how to use them.
c. Ensure availability of telephone numbers for contact with resource providers and advice lines
d. Increase necessary supplies stockpiled in the home to minimize the need to leave the home and the requirement to find supplies in the event of a pandemic.
e. Ensure re-supply mechanisms exist.
f. Wherever possible, train family and friends to meet as many of the care needs as they can and to identify circumstances under which agency care is required.

Pandemic Period - Phase 6

a. Implement alternative care plans for those requiring in-home services to decrease the number of required visits with reliance on family and friends to provide the majority of care.
b. Provide detailed instructions for home care and information on how to obtain telephone consultations.
c. If supplies and medications have not been increased prior to this point, immediately increase, including a 90-day supply of medications.
d. If adequate services cannot be provided in the home setting, consider transfer to a skilled nursing facility.

2. Frail Elderly

Most of the same issues and actions apply to the frail elderly as do to those with disabilities, but there may be even greater limitations in the possibility for self-care. In addition, this group often has a number of chronic medical conditions that require frequent care that will be of limited availability during a pandemic. Available family members may be likewise elderly limiting the ability for family care.

Interpandemic Period - Phase 1 and 2

a. Identify populations at risk with contact information – These have been identified and detailed in the Panhandle Health Preparedness and Response Plan.
b. Ensure development of Continuity of Operations Plans (COOP) – COOPs should be developed for agencies that provide essential services to assure that at least a minimal level of services can be maintained.
    1) In-home health care services for those unable to provide personal care.
    2) Minimal transportation services to ensure the ability to get to health services, if necessary
    3) Home oxygen companies to ensure adequate supplies

Alert Period - Phase 3, 4 and 5

a. Exercise and refine COOP
b. Develop individual emergency care plans and teach people how to use them.
c. Develop alternatives to usual periodic office visits for use during the pandemic period including greater use of telephone triage, telephone advice, telephonic prescribing and potentially home visits.
d. Ensure availability to the elderly and family members of telephone numbers for contact with resource providers and advice lines
e. Increase necessary supplies (both consumables and medical) stockpiled in the home to minimize the need to leave the home and the requirement to find supplies in the event of a pandemic.
f. Ensure re-supply mechanisms exist.
g. Wherever possible, train family and friends to meet as many of the care needs as they can and to identify circumstances under which agency care is required.
h. As possible, practice these plans with the individuals and family/friend caregivers

Pandemic Period - Phase 6

a. Implement alternative care plans for those requiring in-home services to decrease the number of required visits with reliance on family and friends to provide the majority of care.
b. Provide detailed instructions for home care and information on how to obtain telephone consultations.
c. If supplies and medications have not been increased prior to this point, immediately increase, including at 90-day supply of medications.
d. If adequate services cannot be provided in the home setting, consider transfer to a skilled nursing facility.

4. Severely Mentally Ill

These individuals may be vulnerable again in much the same ways as the frail elderly and disabled with a requirement for frequent mental health services. There will be a lack of needed health care appointment slots. However, for this group telephonic services provide a potentially greater avenue for continuing support.

Interpandemic Period - Phase 1 and 2

a. Identify populations at risk with contact information – These have been identified and detailed in the Panhandle Health Preparedness and Response Plan.
b. Ensure development of Continuity of Operations Plans (COOP) – COOPs should be developed for agencies that provide essential services to assure that at least a minimal level of services can be maintained.
    1) In-home health care services for those unable to provide personal care.
    2) Minimal transportation services to ensure the ability to get to health services, if necessary

Alert Period - Phase 3, 4 and 5

a. Exercise and refine COOP
b. Develop individual emergency care plans and teach people (patients, if possible, and caregivers) how to use them.
c. Develop alternatives to usual periodic office visits for use during the pandemic period including greater use of telephone triage, advice, counseling, prescribing and potentially home visits.
d. Ensure availability to patients and family members of telephone numbers for immediate contact with resource providers and advice lines
e. Increase necessary personal care supplies (both consumables and medical) stockpiled in the home to minimize the need to leave the home and the requirement to find supplies in the event of a pandemic.

f. Ensure re-supply mechanisms exist.
g. Wherever possible, train family and friends to meet as many of the care needs as they can and to identify circumstances under which agency care is required.
h. As possible, practice these plans with the individuals and family/friend caregivers

Pandemic Period - Phase 6

a. Implement alternative care plans to provide needed remote counseling and support services to decrease the number of required visits with reliance on family and friends to provide the majority of care.
b. Provide detailed instructions for home care and information on how to obtain telephone consultations.
c. If supplies and medications have not been increased prior to this point, immediately increase, including a 90-day supply of medications. This may not be possible for some psychotropic medications and delivery services may be essential.
d. If adequate services cannot be provided in the home setting, consider temporary admission to a mental health treatment facility.

5. Homeless

This group falls in two categories of concern in that it both depends upon public and private assistance and it consists of people that often shun the avenues for assistance. While the other groups noted above, frequently have engagement with the social support structure or have contacts that will engage on their behalf, homeless persons have limited contact with the health care and social support systems.

The lack of ready contact with health support structures and the active aversion to contact that some in this group may have provides a significant challenge in an environment in which treatment must be started within 48 hours of symptoms if it is to be effective. Lacking the ability to identify and intervene in this group will result in greater morbidity and mortality among these individuals and the potential prolongation of spread to others if they become infected.

This group is also highly dependent upon meal sites for proper nutrition. This provides both a significant vulnerability when closures must occur, but also provides an opportunity for engagement and identification of those needing care in the event that some meal sites can remain open.

Interpandemic Period - Phase 1 and 2

a. Identify populations at risk with contact information for those agencies having direct ability to reach homeless groups and individuals– These have been identified and detailed in the Panhandle Health Preparedness and Response Plan.

b. Ensure development of Continuity of Operations Plans (COOP) for homeless support agencies. COOPs should recognize that sit-down meals may need to be discontinued in favor of take-out meals to simplify operations and minimize person-to-person contact.
c. Design public plans specifically recognizing that normal avenues of food acquisition by homeless support agencies may disappear during a pandemic, so that distribution of food resources must also consider the needs of this population.

Alert Period - Phase 3, 4 and 5

a. Exercise and refine COOP
b. If not previously done, ensure processes are developed to prepare or obtain meals that require limited preparation and may be taken away from the receiving location to consume.
c. Prepare easily understandable educational materials instructing homeless persons on what symptoms they should look for and where and how to receive care in the event that characteristic symptoms develop.

Pandemic Period - Phase 6

a. Implement plans providing alternative meal service.
b. Use meal services to distribute and educate on information for obtaining care.
c. Train homeless support staff to recognize symptoms of illness and utilize meal times to identify potentially ill for referral.
d. Provide transportation to care sites for those identified with potential infection.
e. For those who are spending nights in homeless shelters, particular consideration will need to be given to:
    1) Separation among individuals is required. If residents are such that they sleep alternating head and feet there may be a three-foot separation, but if all are sleeping with their heads in the same direction a six-foot separation is recommended.
    2) Hand hygiene, cough etiquette, and use of alcohol-based hand gels must be taught and enforced.
    3) Masks may be distributed to further decrease the risk of spread of disease since asymptomatic persons may be infectious.

B. Non-English Speaking Populations

These may include both those for whom communication may be an issue due to limited English language capability and those who additionally are in the country illegally and therefore will be concerned about the consequences of self-identification. In addition, there may be cultural barriers associated with seeking and receiving care that must be addressed.

1. Non-English Speaking Citizens and Documented Residents

In these groups, cultural barriers may influence the point at which care is sought and language barriers may limit the ability of public and private agencies to deliver information in a timely fashion. In the North Idaho area there is limited ethnic diversity with the overwhelmingly greatest number among the Spanish-speaking population. The next highest is Asian in heritage, but this is small and represents a somewhat diverse group. In the area primarily in Spokane, but extending east toward Post Falls there is an increasing Serbo-Croatian presence.

Interpandemic Period - Phase 1 and 2

a. Identify populations at risk with contact information for groups that can reliably reach those of each predominant ethnic group– These have been identified and detailed in the Panhandle Health Preparedness and Response Plan.
b. Ensure availability of instructional and personal care information in the languages of the groups identified. (Websites with available information have been identified and are referenced in the tool at the end of this section.
c. Ensure that information on personal and family preparedness in the appropriate languages is available to community groups.

Alert Period - Phase 3, 4 and 5

a. Ensure continuing contact with agencies, religious groups and social organizations associated with the identified groups.
b. As developments progress, ensure specific information is reaching these groups, including through non-traditional channels, since mass media efforts may not be immediately effective.
c. Actively reassess to determine if other ethnic groups have entered the community and need to be engaged.

Pandemic Period - Phase 6

a. Ensure that call lines, triage information, and instructions on receiving care and supplies are provided in the necessary languages.

2. Non-English Speaking Undocumented Residents

In this group, the above concerns all apply, but are compounded by fears on the part of members of this group that any engagement with social systems of public agencies might lead to apprehension and deportation. All efforts must be made to overcome these concerns to ensure that all needing care are identified as early as possible to enable timely treatment and to limit further spread throughout the community.

Interpandemic Period - Phase 1 and 2

a. Identify populations at risk with contact information for groups that can reliably reach those of each predominant ethnic group– These have been identified and detailed in the Panhandle Health Preparedness and Response Plan.
b. Ensure availability of instructional and personal care information in the languages of the groups identified. (Websites with available information have been identified and are referenced in the tool at the end of this section).
c. Ensure that information on personal and family preparedness in the appropriate languages is available to community groups.

Alert Period - Phase 3, 4 and 5

a. Ensure continuing contact with agencies, religious groups and social organizations associated with the identified groups.
b. Emphasize that no questions will be asked regarding status if care is requested.
c. As developments progress, ensure specific information is reaching these groups. Non-traditional channels through advocacy groups and churches may be the primary available means to reach these groups.

Pandemic Period - Phase 6

a. Ensure that call lines, triage information, and instructions on receiving care and supplies are provided in the necessary languages.
b. Continue to take advantage of non-traditional and informal communications channels.
c. Emphasize that early treatment is critical to saving lives and lessening the infection of others.

C. Persons Living in Group Quarters

These encompass a number of groups including some of those already discussed. Homeless shelters have been discussed earlier, but other groups include students living in dormitories such as at North Idaho College, nursing home patients, hospital inpatients and those living in correctional facilities. The same general principles apply in each case in order to prevent spread of disease, but hospital inpatients and nursing home patients have been considered separately in other parts of this plan. Dormitory residents are a special group only if in a communal environment where meals and bathrooms are shared as opposed to an apartment arrangement in which their risk is no greater than others in a similar situation if classes have been discontinued.

1. Incarcerated Persons

Interpandemic Period - Phase 1 and 2

a. Identify populations at risk and contact information including for all correctional facilities – These have been identified and detailed in the Panhandle Health Preparedness and Response Plan.
b. Advise development of Continuity of Operations Plans (COOP). Plans need to include consideration for:
    1) Separation among individuals. This is more difficult in detention facilities since cells will often have more than one individual and meals are usually taken in a communal environment. Options to address this include:
        a) Expanding meal times to enable greater separation in dining facilities due to fewer dining personnel.
        b) Using packaged meals, bagged meals and other foods that can be taken and consumed in cells rather than congregated in a dining facility.
        c) Wearing surgical masks (with metal nasal support removed) while in exercise yards and other communal settings.
    2) Hand hygiene, cough etiquette, and use of alcohol-based hands gels must be taught and enforced.

Alert Period - Phase 3, 4 and 5

a. Exercise and refine COOP
b. If not previously done, ensure processes are developed to prepare or obtain meals that require limited preparation and may be taken away from the receiving location to consume.
c. Provide materials on stockpiling resources.

Pandemic Period - Phase 6

a. Implement plans providing alternative meal service.
b. Use meal services to distribute and educate on information for obtaining care.
c. Train correctional facility staff to recognize symptoms of illness and treatment protocols for in-place care.
d. Ensure re-supply of fluids and care supplies to enable community-level care.

D. Children

Children are often considered among special needs populations, but under circumstances of pandemic influenza schools and day care centers would be closed. Children in group homes would be at risk, but if they are not out into the community their risk is decreased. Measures such as teaching hand hygiene,

cough etiquette, and separation can minimize spread should influenza be introduced.

XIX. FATALITY MANAGEMENT

A. Overview

While mortality planning is the purview of the county coroners, managing mass fatalities on the scale potentially associated with a severe influenza pandemic will be on a scale that few, if any, have dealt with previously. It may become necessary to deploy temporary morgues at county level along with staffing to support the county coroners and their existing limited staff. It should be recognized that many of the staff associated with these sites might necessarily include those whose familiarity with working with deceased individuals may be limited. As a result, this may be among the most stressful tasks for involved personnel.

B. Purpose

The functions of these temporary sites would include:

- Remains collection
- Remains storage in a controlled environment while awaiting disposition
- Collection of information about the deceased for administrative, notification and epidemiological purposes
- Assistance in issuing death certificates and other postmortem documentation
- Locating family members of deceased persons when these are unknown
- Assisting family members in arrangements for interment or other disposition of remains
- Assisting local authorities in disposition of unclaimed remains

C. Location

The location of the temporary morgue will be determined by the county coroner/medical examiner in consultation with Panhandle Health and coordinated with county governmental authorities and Emergency Operations Center.

Specific site and configuration will depend upon the number of deceased, their condition, the availability of refrigeration and other logistical requirements and the need for space to perform administrative and other operational tasks.

Additional Considerations:

1. Communications and computer access should also be available to facilitate effective operations.

2. Vehicles must have easy access to the location and, if refrigerated trucks are to be used, sufficient parking space must be available. There must also be adequate availability or access to fuel. In addition, any company markings visible on the vehicles should be masked to

prevent identification. Stored remains will be bagged to prevent contamination of the trucks themselves.

3. The area must be possible to secure to prevent unauthorized access. Entry and exit points should be clearly marked and access controlled.

4. The site should be amenable to the use of forklifts for movement of palletized cargo or remains.

5. Hot and cold water must be available or other adequate means of cleaning and decontamination.

6. There must be an adequate break area for staff, the ability to get refreshments and the presence of adequate restrooms.

D. Personnel

Potential staffing for temporary county morgue support under the direction of the County Coroner might include:

Morgue Director
- Providing oversight of day-to-day operations of the site
- Site personnel management

Deputy Morgue Director
- Provide additional oversight
- Direct site personnel supervision

Remains Collection
- Collection may be restricted to the on-site location or it may be determined that remains will be picked up from collection sites or individual homes in the community.
- If collection is performed in the community, these individuals would also be responsible for collection of key identification information associated with the remains of any individual picked up.

Recording
- These individuals will be responsible for preparing death certificates, accounting for documentation on personal items collected, etc.

E. Operations

1. General

   The temporary morgue is designed only to serve as a facility or function to provide temporary storage of remains that are excess to the ability of normal capacity. At the earliest time possible, individual remains will be managed through normal mortuary procedures and organizations.

At all times, the families of deceased individuals will be included in decision making and planning for the remains of their loved ones. To the greatest extent possible, religious and cultural desires will be considered; however volume and the nature of the crisis may limit or eliminate the ability to adhere to many religious and cultural expectations. Any family requiring specific religious or cultural practices will be directly responsible for disposition of remains consistent with those practices.

The institution of "mass graves" will not occur until there are no other appropriate alternatives to storage and individual interment. Cremation may be a considered alternative consistent with arrangements with next of kin.

2. Remains Collection

While it may impractical for next of kin, care agencies and other organizations to physically bring the bodies of deceased persons to a central collection point, availability of personnel, vehicles and the number of potential victims may make this a necessity. However, the primary method of remains collection will by dispatched vehicles.

Key considerations are the potential exposure of further personnel to acquiring infection. In general, remains will not have the same infectivity as a living individual since the primary mode of disease communication is the expelling of live virus from the respiratory system of an infected individual. The primary risk to workers collecting remains is related to entering the homes of deceased in which other infected individuals may be living.

F. Decedent Records

Other than the essential requirements for death certificates, cause of death reporting during a pandemic will be an important part of epidemiological tracking. Data will need to be provided on an ongoing basis which, in combination with hospital data on illnesses, will enable an assessment of severity, anticipated duration of the wave and better projections for resource needs.

G. Personal Effects Management

Whenever possible, personal effects should not be transported with remains. All effects, excepting some means of identification, should remain with family members. Under those circumstances in which personal effects have come with the remains, these must be collected, inventoried and secured pending return to relatives. A secure location, either a safe or a locked room with limited access, will need to be established. Individual containers for each individual should be used and sealed with tape to minimize the risk of tampering. Effects should be returned to the appropriate next of kin as soon as possible.

H. Remains Management

Remains should be handled as would those of any decedent with an infectious disease. This involves the use of appropriate personal protective equipment and surface disinfection. Unless pandemic influenza has a means of transmission unlike that of other varieties of influenza, its primary mode of transmission is via coughed aerosols which come in contact with recipient mucous membranes. This would not occur following death, so routine precautions should be wholly adequate to prevent infection of those managing remains.

Storage of remains should be in impermeable bags under refrigeration, if possible, in order to limit decomposition prior to release to funeral homes. Funeral home management should again involve precautions and release of bodily fluids should be minimized.

I. Logistical Support

Required support will likely include:
Personnel – Derived from screened volunteers
Refrigeration storage - Arranged through the Emergency Operations Center
Body bags – Acquired through the Emergency Operations Center
Transport vehicles – Provided through county assets

J. Site Personnel Support

If the volume of deceased persons reaches a point at which volunteer personnel need to be utilized in remains management, it will be critically important to provide mental health support for workers who may be overwhelmed by circumstances never before faced. Even seasoned workers may be overwhelmed by the number of deceased and may need support.

Primary support will be through the counseling line established for pandemic support workers. This counseling line will be housed at Panhandle Health and staffed by volunteers from the Medical Reserve Corps. If direct visits are needed these can be arranged through the same phone number, however, availability will be limited.

Support will need to continue after the event has passed since post traumatic stress disorder can be associated with the degree of psychological trauma that can occur under these circumstances.

XX. PLAN MANAGEMENT, TRAINING AND EXERCISES

A. Overview

Any plan must be a living document continually undergoing development as information changes, organizational needs mature and exercises reveal opportunities for improvement. This plan will undergo multiple modifications as a result of this process on the way to ensuring a plan that will best meet the needs of northern Idaho.

B. Maintenance

1. Along with all Public Health Preparedness (PHP) plans, this plan will be reviewed and updated at least annually though more frequent updates may be performed as indicated.

2. PHP will review lessons learned from all exercises for impacts on the plan and incorporate appropriate changes.

3. Any person at any time may submit a recommended change to PHP for consideration as part of the annual review or for earlier inclusion if the situation warrants.

4. PHP will submit the plan annually to the executive staff for review.

C. Training

1. Internal Panhandle Health District training on this plan will occur accordance with the annual training plan.
2. External (partner and public) training will occur also as determined by the annual training plan; however further opportunities will be used whenever the opportunity permits or as interest is indicated.

D. Exercises

1. Exercises relative to this plan will occur as defined in the overarching Panhandle Health District Preparedness and Response Plan and with a schedule defined in the annually published exercise plan.
2. Exercises will be designed to exercise portions of the plan in a process of further development, with exercises culminating to a point at which full-scale exercising of the plan is possible.
3. Exercises will involve partners of the PMACG to the maximum extent possible.

Acknowledgements

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It is with sincere gratitude that it is acknowledged that many other plans have contributed ideas to this Panhandle Health Pandemic Influenza Plan.

The National pandemic influenza plans of:
The United States
The United Kingdom
Canada

The State plans of:
Idaho
New York
Rhode Island
Georgia
Maine
California
Missouri

County and Regional plans too numerous to all name, but particularly:
Santa Clara County, California
Seattle, King County, Washington
Los Angeles, California
Tacoma-Pierce, Washington